

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
**PREA**  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

<b>Final Report</b>	
Name of facility: Algoa Correctional Center (ACC)	
Physical Address: 8501 No More Victims, Jefferson City, Mo. 65101-4567	
Date report submitted: March 10, 2016	
<b>Auditor Information</b>	
Address: 2323 Ave. J. Omaha, Ne. 68110 / 2610 N. 20 <sup>th</sup> Street. Omaha, Ne. 68110	
E-Mail: <a href="mailto:brad.mcdonnell@nebraska.gov">brad.mcdonnell@nebraska.gov</a> / <a href="mailto:Trish.Brockman@nebraska.gov">Trish.Brockman@nebraska.gov</a>	
Telephone number: (402) 522-7013 / (402) 595-2000	
Date of facility visit: August 17 – 19, 2015	
<b>Facility Information</b>	
Facility mailing address: (if different from above)	
Telephone number: (573) 751-3911	
The facility is:	
<input type="checkbox"/> Military	<input type="checkbox"/> County
<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal
<input type="checkbox"/> Private not for profit	<input checked="" type="checkbox"/> Federal
	<input checked="" type="checkbox"/> State
Facility Type: <input type="checkbox"/> Jail <input checked="" type="checkbox"/> Prison	
Name of PREA Compliance Manager: Bill Schmutz	Title: Deputy Warden
E-Mail Address: Bill.Schmutz@doc.mo.gov	Phone Number: (573) 751-3911
<b>Agency Information</b>	
Name of agency: Missouri Department of Corrections	
Governing authority or parent agency: (if applicable) State of Missouri	
Physical address: 2729 Plaza Drive, Jefferson City, MO 65102	
Mailing address: (if different from above)	
Telephone Number: 573-751-2389	
<b>Agency Chief Executive Officer</b>	
Name: George Lombardi	Title: Director of Corrections
E-Mail Address: George.Lombardi@doc.mo.gov	Telephone Number: 573-751-2389
<b>Agency-Wide PREA Coordinator</b>	
Name: Vevia Sturm	Title: PREA Coordinator
E-Mail Address: Vevia.Sturm@doc.mo.gov	Telephone Number: 573-751-2389

## **AUDIT FINDINGS**

### **NARRATIVE:**

The site visit for the PREA Audit of the Algoa Correctional Center (ACC) was conducted on August 17 – 19, 2015. The PREA audit team consisted of Trish Brockman-Bernhards, NDCS/ DOJ Certified PREA Auditor, Brad McDonnell, NDCS/DOJ Certified PREA Auditor, Stephanie Huddle, NDCS/DOJ Certified PREA Auditor, Deanna Johnson, NDCS/DOJ PREA Auditor. During the pre-audit phase, the team divided and reviewed standards and completed a large portion of the file review prior to the site visit.

An entrance meeting was held at the beginning of our on-site visit. The following ACC staff attended: Scott A. Lawrence, Warden, Bill Schmutz, Deputy Warden/PREA Compliance Manager, Louisa Bolinger, Deputy Warden, Sandra Jimmerson, Assistant Warden, Major Vallier, Chief of Security, Bryan Skiles, Administrative Inquiry Officer (AIO) and 18 additional staff members. The audit team shared what our plan of action was going to be for the next three days. We discussed what areas of the facility we needed to tour and explained we would be interviewing inmates and staff.

After the entrance meeting, the tour of the facility occurred. During the tour it was noted that each housing unit had adequate information regarding PREA and the contact information for the audit chairperson. Each area was properly supervised by either staff and/or video monitoring. Additional documentation review was conducted.

Offenders interviewed were chosen randomly from rosters obtained by the audit team. Offenders related an awareness of the agency and facility zero tolerance policy and indicated PREA information is made available to them. Offenders also related they were aware of the avenues available to report an incident of sexual abuse or sexual harassment. The team interviewed 35 offenders, including 30 random inmates from each living unit; (2) had disclosed sexual victimization during risk screening; (1) inmate who identified as gay, bisexual or transgender; (1) Spanish speaking inmate; (1) inmate who had reported sexual abuse.

A total of 27 random staff interviews were completed in addition to all specialized staff interviews. Interviews were conducted with the Director of the Division of Adult Institutions, the facility administration to include the Warden, the PREA Compliance Manager, Medical and Mental Health staff, segregated housing staff, the Agency Contract Monitor, staff responsible for retaliation monitoring, Case Managers, Investigators, and Security staff from each of the three shifts. There were (4) volunteers and contractors also interviewed. Staff and volunteers were knowledgeable of ACC and agency policy in regards to their responsibilities in the event of a sexual abuse or a sexual harassment incident.

### **DESCRIPTION OF FACILITY CHARACTERISTICS:**

The Algoa Correctional Facility is a minimum security institution located in Jefferson City, Missouri that houses adult male offenders. The population during the time of the audit was 1530 male offenders. ACC Does not house youthful offenders. The average age range is 19-71. The facility has 11 living units and numerous other buildings to include several maintenance buildings, shop areas, food service, education, chapel, etc. Cameras are located throughout the facility and have been increased over the last decade.

## **SUMMARY OF AUDIT FINDINGS:**

All staff interviewed was knowledgeable, particularly with their reporting requirements and the immediate action needed in order to ensure inmate safety. Inmates were familiar with PREA and knew the various reporting methods offered to them. PREA posters and information was readily available throughout the facility.

During the on-site audit, there were four standards that were not met. These standards were 115.15, 115.43, 115.68, 115.71. A 180-day corrective action period was initiated that allowed ACC to submit documentation and construct privacy barriers in the living units. For Standard 115.15 the facility provided documentation that brought this standard into compliance. For Standard 115.43 the facility provided further documentation indicating that inmates are transferred as an alternative to Protective Custody. They also provided documentation showing further administrative segregation issues existed if an inmate was kept in restrictive housing. In regards to Standard 115.71, the facility provided revised MDOC Procedure that indicated documentation would be retained for 90 years. This would meet the intent of the standard. With these corrections and modifications ACC is now in full compliance with all PREA standards.

Each individual standard will have comments and further documentation that will reflect how/why compliance/noncompliance was determined.

Number of standards met: 41

Number of standards not met: 0

Number of standards exceeded: 1

Number of standards not applicable: 1

115.11	ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> ACC has policy outlining their zero-tolerance standard regarding sexual abuse in confinement. While not every standard is written in policy, those that are required to be are in policy and the facility meets the standards in practice and procedures. An agency-wide PREA Coordinator position has been established and she is actively involved with the facility's efforts towards compliance. A facility PREA Compliance Manager has been identified; he demonstrates excellent knowledge of the standards and his compassion and conviction are evident in the work he does.	

115.12	CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF OFFENDERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation indicates MODOC does not enter into contracts for the confinement of offenders.	

115.13	SUPERVISION AND MONITORING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> ACC complies with a staffing plan that ensures safety and security is maintained. Deviations from the plan are documented. Documentation was provided showing the PREA Coordinator is actively involved in the review of staffing plans and all elements required by the standards are taken into consideration. Supervisors conduct unannounced rounds on all shifts throughout the facility.	



115.14	YOUTHFUL OFFENDERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC does not house youthful offenders. Therefore, this standard is not applicable.</b>	

115.15	LIMITS TO CROSS GENDER VIEWING AND SEARCHES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC staff does not conduct cross gender strip or body cavity searches. No cross gender strip or body cavity searches had been conducted in the past 12 months. Transgender offenders are not searched for the sole purpose of determining genital status, and all staff is trained to conduct cross gender pat searches in a respectful manner while still keeping security needs in mind. Documentation from the Director and facility Post Orders indicate proper procedure are in place regarding cross gender announcements being made on living units. Documentation was provided that procedure is being followed. Photographs indicate that barriers were installed to limit cross gender viewing in living units, visiting dress out and the multi-purpose building restroom.</b>	

115.16	OFFENDERS WITH DISABILITIES AND OFFENDERS WHO ARE LIMITED ENGLISH PROFICIENT
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place to ensure offenders with disabilities have equal access to PREA information. Information is also available in formats to provide such information. ACC does not rely on offender interpreters, however, staff and offender interviews indicate the use of offender interpreters does occur. It was recommended that all staff be reminded that the use of offender interpreters should not be relied upon except in limited circumstances where an extended delay in obtaining an effective interpreter could compromise the offender's safety, the performance of first-responders duties.</b>	

115.17	HIRING AND PROMOTION DECISIONS
<input checked="" type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC does not hire or promote individuals who have engaged or been convicted of sexual abuse/assault in a confinement setting or in the community, or who have been civilly adjudicated of such an incident. Occurrences of sexual harassment are taken into consideration when determining whether or not to promote a staff member. Potential employees undergo a thorough background check, as do contractors who may have contact with offenders. Potential employees are asked about any prior incidents of sexual abuse/assault with the understanding omitting or falsifying information may result in termination. Background checks are conducted every year on current employees in conjunction with birthday.</b>	

115.18	UPGRADES TO FACILITIES AND TECHNOLOGY
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC takes offender safety very seriously. PREA is a component of expanding any portion of the facility and also when determining what, if any, additional video monitoring and other technology should be utilized. The facility has had a substantial increase in the use of video surveillance over the last 10 years.</b>	

115.21	EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC conducts administrative investigations internally. Criminal investigations are conducted by the Agency Inspector General (IG). Forensic exams are conducted off-site by SANEs/SAFE's in Columbia Mo. and provided at no cost to the victim. The on-site Chaplain serves as Victim advocates and is available to offender victims at no charge. This person is trained and procedures are outlined in agency policy.</b>	

115.22	POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>All allegations meeting PREA criteria are investigated, either internally through the Administrative Inquiry Officer (AIO) or through the IG for criminal investigations. All allegations within the past 12 months were investigated. The MODOC website provides information regarding the MODOC's responsibility to investigate criminal allegations.</b>	

115.31	EMPLOYEE TRAINING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC is responsible for training all of their staff. The required elements of the training are met. Employees are trained in PREA on an annual basis and it can be verified the training was completed and understood.</b>	

115.32	VOLUNTEER AND CONTRACTOR TRAINING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>All volunteers and contractors receive appropriate training. Documentation of such training is maintained.</b>	

115.33	OFFENDER EDUCATION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Offenders receive comprehensive education within 1-2 days upon arrival at the facility, which is significantly above the 30 day requirement. During the past 12 months, 1749 offenders received the comprehensive education. All offenders who were previously on-site received the same information. Education is provided in formats accessible to all offenders. Although posters were present, they were not highly visible during the tour; it is recommended that more colorful posters be placed in living units and other common areas used by the offenders.	

115.34	SPECIALIZED TRAINING: INVESTIGATIONS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Investigators complete training specific to conducting PREA investigations. The training includes techniques for interviewing sexual abuse victims, proper use of Miranda and Garrity warnings, sexual abuse evidence collection in confinement settings and criteria required to substantiate an administrative case. Documentation is maintained showing staff attended the training. MODOC has 56 staff that has completed the required training.	

115.35	SPECIALIZED TRAINING: MEDICAL AND MENTAL HEALTH CARE
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> In addition to the regular PREA training, all full and part time medical and mental health care practitioners receive training in how to detect and assess signs of sexual abuse/harassment, how to preserve physical evidence of sexual abuse, how to respond in a professional and respectful manner and how to report incidents/suspicious. All medical and mental health care practitioners who work there on a regular basis; 100% of these staff have received the required training. Documentation of the training is maintained.	

115.41	SCREENING FOR RISK OF VICTIMIZATION AND ABUSIVENESS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders are assessed upon intake for their risk of being sexually abusive or abused within 24 hours of their arrival at the facility. ACC assessment form indicates not all offenders were reassessed within 30 days. It was recommended that the form be modified to include a column to clarify why these offenders exceeded the 30 day time frame.</b>	

115.42	USE OF SCREENING INFORMATION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Information from screening is used when placing offenders in housing, work or programming assignments. Individual determinations regarding individual safety, staff interviewed who are responsible for risk screening ensured this does take place. Any housing/programming for transgender offenders is decided on a case-by-case basis; policy is in place ensuring placement of transgender and intersex offenders is reviewed at least twice each year. Policy also ensures transgender offenders' own views regarding their safety will be given consideration and they are given the opportunity to shower separately.</b>	

115.43	PROTECTIVE CUSTODY
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place prohibiting the placement of offenders at high risk for sexual victimization in involuntary segregation/protective custody. Reviews of segregation status for sexual safety are done every 30 days. Documentation was provided that indicated that individuals placed in segregated housing were not placed solely for the purpose of involuntary segregation/protective custody. Inmates who did request protective custody were transferred to another MDOC facility as an alternative to the segregation placement.</b>	

115.51	OFFENDER REPORTING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders have multiple methods to report allegations of abuse/harassment. During interviews, all offenders were aware of how they could report an incident. Offenders have both an outside reporting mechanism and an anonymous hotline available to them. Staff is required to accept all reports, and expressed understanding of this policy during interviews. Staff was also aware they could call a reporting hotline in order to report an allegation privately.</b>	

115.52	EXHAUSTION OF ADMINISTRATIVE REMEDIES	OFFENDER REP
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)		
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC has policy regarding grievances dealing with sexual abuse, upon which no time limit is imposed. Offenders are not required to first use an informal grievance process or attempt to resolve the issue with staff. Offenders may submit grievances to staff other than those involved with the grievance; the grievances are not referred to the staff member who is the subject of the complaint. Third parties may assist offenders with filing grievances; there were no such grievances within the past 12 months. Policy exists regarding emergency grievances; there were no emergency grievances files at ACC pertaining to risk of sexual abuse within the past 12 months.</b>		

115.53	OFFENDER ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES	OFFENDER REP
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)		
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders have access to outside victim support services. The provider of these services was interviewed and was able to clearly articulate procedures for assisting incarcerated victims. Flyers and posters, observed during the tour, were also readily available at the facility. Offenders understand the confidentiality requirements of these services.</b>		

115.54	THIRD-PARY REPORTING
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Third parties can report allegations through a telephone hotline. Information is on the agency website.</b>	

115.61	STAFF AND AGENCY REPORTING DUTIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>All staff is required to immediately report any incident or allegation of sexual abuse or retaliation; staff interviewed was very familiar with these requirements. They were also aware of the need for discretion. Medical and mental health staff was familiar with their reporting requirements and limitations on confidentiality and informed the offenders of such during initiation of services. MODOC is considered a mandatory reporter under Missouri law for anyone under age 18. All allegations are referred for investigation and given to investigative staff.</b>	

115.62	AGENCY PROTECTION DUTIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place regarding immediate protection of offenders. All staff interviewed were extremely knowledgeable about these requirements and knew what to do if an offender reported an allegation to them.</b>	

115.63	REPORTING TO OTHER CONFINEMENT FACILITIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place requiring notification to another facility in the event an allegation is made while at ACC. This notification occurs within 72 hours and is documented. ACC received no notifications within the past 12 months from other facilities.</b>	

115.64	STAFF FIRST RESPONDER DUTIES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC has policy regarding actions taken by first responders. There were 4 allegations an offender was sexually abused in the past 12 months. Of these, the alleged victim and perpetrator were separated by the first security staff member on scene. There were no allegations where staff was notified within a time period allowing for evidence collection.</b>	

115.65	COORDINATED RESPONSE
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC has a written plan that was provided prior to the on-site audit outlining responsibilities of first responders, medical/mental health practitioners, investigative staff and facility leadership.</b>	



115.66	PRESERVATION OF ABILITY TO PROTECT OFFENDERS FROM CONTACT WITH ABUSERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>ACC has not entered into or renewed any collective bargaining agreement or other agreement that would limit the agency's ability to remove alleged staff sexual abusers from contact with any offenders pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.</b>	

115.67	AGENCY PROTECTION AGAINST RETALIATION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>The PCM is responsible for monitoring retaliation and was able to articulate how he does this and what he does to ensure incidents of retaliation are not occurring. Multiple protection measures are employed. Staff and offenders are monitored for a minimum of 90 days but will be extended if necessary. There were no occurrences of retaliation within the past 12 months.</b>	

115.68	POST-ALLEGATION PROTECTIVE CUSTODY
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Existing policy prohibits placing offenders who allege they suffered sexual abuse in involuntary segregation/protective custody unless no other reasonable means to ensure safety can be determined. Any offenders exceeding 30 days are documented by the facility regarding concern and the reason(s) why no alternative separation could be arranged. An offender's status is reviewed every 30 days.</b>	

115.71	CRIMINAL AND ADMINISTRATIVE INVESTIGATIONS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place regarding both administrative and criminal investigations. All staff who investigates sexual abuse/harassment is required to take specialized training. A review of a sample of investigations showed all elements required by the standard are in place. Any substantiated cases of criminal conduct are referred for prosecution by MODOC. The PCM described the cooperation between ACC and the IG and how the facility remains informed of criminal investigations. There were no such investigations since August 2012. The retention schedule was changed to reflect that all reports and investigations are held for 90 years.</b>	

115.72	EVIDENTIARY STANDARDS FOR ADMINISTRATIVE INVESTIGATIONS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy ensures preponderance of the evidence is the standard of proof in determining whether allegations of abuse or harassment are substantiated. The AIO articulated how he reaches such decisions with his investigations.</b>	

115.73	REPORTING TO OFFENDERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders are notified of the results of the investigation into their allegations. Offenders are also notified of the status of offender or staff perpetrators, including whether or not there is an indictment or conviction as a result of the investigation; all notifications are documented. Although the standard is met, the recommendation is being made for the facility to be consistent with Federal Law and PREA standards utilizing Substantiated, Unsubstantiated, and Unfounded verbiage.</b>	

115.76	DISCIPLINARY SANCTIONS FOR STAFF
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy is in place regarding staff disciplinary sanctions. In the past 12 months, 2 staff violated sexual abuse/harassment policy; one staff was terminated/resigned prior to termination, the other had resigned prior to the allegation being made. Policy is in place to ensure actions that may be criminal are reported to IG and relevant licensing bodies.</b>	

115.77	CORRECTIVE ACTION FOR CONTRACTORS AND VOLUNTEERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Policy ensures contractors and volunteers who sexually abuse offenders are prohibited from contact with them and referred to relevant licensing bodies, as well as IG when the alleged act may be criminal in nature. Appropriate remedial measures are taken for other violations of PREA policy.</b>	

115.78	DISCIPLINARY SANCTIONS FOR OFFENDERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders are subject to discipline for perpetrating sexual abuse and harassment. There were no instances of substantiated administrative or criminal findings an offender perpetrated sexual abuse. Sanctions are commensurate with past history, the nature of the offense and comparable sanctions given to other offenders for the same type of misconduct, along with consideration to an offender's mental health status, including the consideration of therapy. Offenders are not disciplined for having sexual contact with staff, unless the staff member did not consent to the contact. Offenders are not disciplined for making reports in good faith, even if the allegation is determined to be unfounded. ACC policy does prohibit consensual sexual contact/activities between offenders.</b>	

115.81	MEDICAL AND MENTAL HEALTH SCREENINGS; HISTORY OF SEXUAL ABUSE
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offenders are offered a follow-up meeting with medical or mental health staff within 14 days if they disclose prior sexual victimization or perpetration during risk screening. In the past 12 months, 100% of offenders who disclosed such victimization were offered the follow-up meeting. Information is kept as confidential as possible, with information shared for the purpose of housing/living, programming and work assignments.</b>	

115.82	ACCESS TO EMERGENCY MEDICAL AND MENTAL HEALTH SERVICES
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Offender victims receive timely access and information regarding treatment and available treatment options, including emergency contraception and sexually transmitted infections. All treatment is provided at no cost to the offenders.</b>	

115.83	ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>All offender victims, regardless of whether abuse occurred at ACC or another confinement facility, are offered medical and mental health evaluations, including testing for sexually transmitted infections. Such treatment includes plans for follow-up care in the event they are transferred to another facility ore released from custody. All treatment is provided at no cost to the offenders. ACC has policy in place ensuring staff attempt to conduct a mental health evaluation of offenders who abuse other offenders.</b>	

115.86	SEXUAL ABUSE INCIDENT REVIEWS
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Sexual abuse incident reviews are conducted by the appropriate staff within 30 days upon the closing of an investigation for all allegations determined to be substantiated or unsubstantiated. The PREA Compliance Manager, Chief of Security and Assistant Warden, medical/mental health staff are involved in these reviews. All required elements are taken into consideration.</b>	

115.87	DATA COLLECTION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Data is collected and aggregated annually and the Survey of Sexual Violence is submitted within the time frame outlined by the governing agency of that form. Data is maintained and collected from documents, investigations, incident reviews and other available reports.</b>	

115.88	DATA REVIEW FOR CORRECTIVE ACTION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <b>Collected data is reviewed to identify problem areas, make corrective action plans (when needed). Said data is used in annual reports for individual facilities and the MODOC. Data will be compared from the previous year in order to assess progress and concerns. These reports are approved by the Commissioner and are available on the MODOC website; in the event the reports contain identifying information, it will be redacted prior to publication.</b>	

115.89	DATA STORAGE, PUBLICATION, AND DESTRUCTION
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>All collected data is securely retained. Annual reports pertaining to this data are available on the MODOC website; identifying information, if any, is removed prior to being published. Data is retained at least 10 years.</b>	

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

Name of facility: Cremer Therapeutic Community Center (CTCC)	
Physical Address: 689 Route O, Fulton, MO 65251	
Date report submitted: 05/08/2015	
<b>Auditor Information:</b> Ron Baker, Liz Rice	
Address: Kansas Dept of Corrections, 714 SW Jackson, Suite 300, Topeka, KS 66603	
E-Mail: <a href="mailto:ron.baker@doc.ks.gov">ron.baker@doc.ks.gov</a> ; <a href="mailto:liz.rice@doc.ks.gov">liz.rice@doc.ks.gov</a>	
Telephone number: 785-296-4501	
Date of facility visit: April 13-14, 2015	
<b>Facility Information</b>	
Facility mailing address: 689 Route O, Fulton, MO 65251	
Telephone number: 573-592-4013	
The facility is: <input type="checkbox"/> Military <input type="checkbox"/> County <input type="checkbox"/> Federal <input type="checkbox"/> Private for profit <input type="checkbox"/> Municipal <input checked="" type="checkbox"/> State <input type="checkbox"/> Private not for profit	
Facility Type: Adult Prison	
Name of PREA Compliance Manager: Kim Crouch	Title: Deputy Warden
E-Mail Address: <a href="mailto:Kimberly.crouch@doc.mo.gov">Kimberly.crouch@doc.mo.gov</a>	Phone Number:
<b>Agency Information</b>	
Name of agency: Missouri Department of Corrections	
Governing authority or parent agency: (if applicable) State of Missouri	
Physical address: 2728 Plaza Drive Jefferson City, MO 65109	
Mailing address: (if different from above)	
Telephone Number: 573-526-9003	
<b>Agency Chief Executive Officer</b>	
Name: George Lombardi	Title: Director
E-Mail Address: <a href="mailto:George.Lombardi@doc.mo.gov">George.Lombardi@doc.mo.gov</a>	Telephone Number: (573) 526-6607
<b>Agency –wide PREA Coordinator</b>	
Name: Vevia Sturm	Title: PREA Coordinator
E-Mail Address: <a href="mailto:Vevia.Sturm@doc.mo.gov">Vevia.Sturm@doc.mo.gov</a>	Telephone Number: (573) 522-1634

# AUDIT FINDINGS

## NARRATIVE:

In order to determine compliance with Prison Rape Elimination Act (PREA) standards an on-site audit was conducted of the Cremer Therapeutic Community Center (CTCC) on April 13-14, 2015 by DOJ certified auditors Liz Rice and Ron Baker and one assistant, C. J. Perez. Perez received training prior to the audit and supervision during the process from Baker and Rice.

Prior to the on-site portion of the audit, auditors provided the facility with the Auditor Notice which was posted at least 6 weeks prior to the on-site audit. The Pre-Audit Questionnaire along with other supporting documentation was provided to the auditors to review in advance of the on-site portion of the audit. Auditors appreciated the very well organized questionnaire with supporting documentation that was received and reviewed prior to the on-site visit. The same auditors conducted an on-site visit to another MDOC facility the same week and appreciate the CTCC willingness to be flexible with the schedule to accommodate both visits.

The auditors received the pre-audit questionnaire prior to the on-site visit and met to review the documentation provided prior to their arrival in Fulton, MO. The questionnaire was well organized and provided appropriate documentation to support their self assessment of the standards.

The auditors reported to CTCC on 04/13/2015 at 09:00 hrs to complete an introductory meeting and a tour of the facility. Present at the meeting were Warden , Assistant Warden and state PREA Coordinator . Immediately following the meeting the staff provided a tour for auditors that included all areas in the building and yard where inmates may be present . During the tour Asst Warden provided an overview of the mission of the facility and an explanation of how offenders are admitted and released from the facility. Auditors were able to observe staff and offender interaction during the tour and noticed the positive culture among staff.

Following the tour the audit team discussed the audit schedule with Asst Warden to ensure that the schedule would not conflict with the operational needs of the facility and provide ample opportunity for auditors to complete their required tasks. Offender and staff rosters were provided for the audit team to select people for random and targeted interviews. Staff interviews were conducted on the afternoon of 4/13 for staff on the 7-3 and 3-11 custody shifts. Auditors returned to the facility at 23:00 hrs to interview staff on the 11-7 shift. Staff interviews included 10 randomly selected custody line staff, custody shift supervisor, chief of custody, warden, PREA Compliance Manager, medical staff, treatment/program staff manager, intake staff, canteen staff, and probation/parole staff. All staff interviewed clearly understood their roles with regards to PREA. Human Resource, Mental Health and Investigative staff were not interviewed as they are dispatched from a nearby facility when needed. These staff were interviewed during the audit of FRDC on 4/14-16, 2015 and there were no deficiencies noted in the standard related to those sections. SAFE/SANE exams are conducted off site by the University of Missouri Hospital. Staff from that facility were not interviewed.

Offender interviews were conducted on 4/14/2015 and included at least one offender from each housing unit, an offender who had reported sexual abuse, an offender who self-identified as gay, and an offender identified as vulnerable during risk screening.

Auditors were given complete access to all areas of the facility.

At the conclusion of offender interviews the auditors prepared for a final exit interview/briefing with senior staff. Those in attendance for exit briefing were Warden, Asst. Warden, and State PREA Coordinator.

Members of this audit team have participated in two other audits of Missouri DOC facilities. During those audits interviews were conducted with State PREA Coordinator and Agency Head/Designee, therefore new interviews were not conducted during this on-site visit as previous interviews have been satisfactory.

The pre-audit questionnaire was well organized and contained the necessary supporting documentation. There were no deficiencies noted and the assessed strengths were staff buy-in to the PREA standards, staff training and their retention of information related to PREA, and the commitment of the warden and asst. warden to educate staff and inmates about PREA.

## DESCRIPTION OF FACILITY CHARACTERISTICS

CTCC is a 180 bed substance abuse treatment facility operated by the Missouri Department of Corrections. CTCC was opened in 1994 in a converted State Hospital building and currently houses only adult male offenders. The facility is contained in a single building that includes 6 dormitory style housing units, treatment rooms, food service, recreation, visiting, and administrative areas (including a laboratory for drug testing). There are 2 segregation cells. Offenders at CTCC are at the end of their sentence



and release from CTCC to the streets.

Because of the age of the building and the original use there are many blind spots that they have attempted to cover with the use of cameras and staff monitoring. Auditors recommend the addition of cameras in the stair wells and dish room.

Number of standards exceeded: 0

Number of standards met: 43

Number of standards not met: 0

Number of standards not applicable: 0

<b>115.11</b>	<b>ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency has written policy D1.8.13 Offender Sexual Abuse and Harassment mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines prevention, detection and responding to reports and mandates more specific procedures at the facility level.</p> <p>The PREA Coordinator and PREA Compliance Manager stated they have sufficient time and authority to develop and oversee compliance and each facility has a designated PREA Compliance Manager. The PREA Coordinator reports directly to agency Legal Counsel, and the PREA Compliance Manager, who is also the Assistant Warden at CTCC reports directly to the Warden.</p>	
<b>115.12</b>	<b>CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>CTCC does not contract with other entities for the confinement of offenders. The MDOC, as parent agency, contracts with 4 community confinement facilities, although none of them are specifically tied to this facility. The agency contract administrator draws up the contracts while the probation/parole division monitors compliance. Current contracts require the facilities to be PREA compliant to include a PREA audit this year. Additionally probation and parole staff conduct compliance audits every 6 months.</p>	
<b>115.13</b>	<b>SUPERVISION AND MONITORING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 mandates that each facility maintains a staffing plan that provides for adequate staffing levels as well as an annual review of the staffing plan which includes the consultation of the PREA Coordinator. The average daily number of offenders at CTCC is 174 and the staffing plan is predicated on a maximum base of 180 offenders. Each required element was documented in "The PREA Staffing and Yearly Reporting Implementation Team" report, which was provided in the PAQ documentation for review. Regarding deviations from the staffing plan, it states, "Deviations from those established staffing patterns is reflected within shift summary reports, custody staffing rosters, custody overtime records and shift chronological logs. This documentation may include notation within activity logs reflecting activities that were canceled or rescheduled to a time when adequate supervision was present."</p>	

Agency policy D1-8.13 and facility policy mandates unannounced rounds by supervisory staff. This is achieved in part, through post orders (IS20 -1.1) for custody supervisory staff. Policy dictates that chief administrative officers ensure all staff post orders "include a general order prohibiting staff from alerting other staff members that supervisory rounds are occurring, unless such announcement is related to legitimate operational functions of the facility." These rounds are documented in the PREA rounds section of the "Shift Supervisors Weekly Institutional Inspection Worksheet" which were made available for the auditors review. Additionally, specific to CTCC and also per IS20-1.1 (post orders), "Due to being one housing unit, CTCC does not use the staff member sign-in form, shift supervisors will record their unannounced rounds on their security inspection form. Each week, the shift supervisors will submit their security inspection form to the chief of custody which will include their unannounced supervisor rounds."

In response to standard 115.13(b) regarding deviations from the staffing plan, CTCC advised that there was one occasion in which the staffing level dropped below the minimum allowed. Documentation was provided to include a memo from the Chief of Security to the Asst. Warden (of whom is also the PREA Compliance Manager). The memo explains that an officer left shift without authorization and that although an additional staff was called, the 3rd shift was below minimum staffing levels for a short period of time.

CTCC provided meeting minutes from its annual "Security Camera and Staffing Plan PREA Review Meeting". Agenda items included the requirements of standard 115.13 (section C specifically) which outlines that in consultation with the PREA coordinator required by 115.11, the agency shall assess, determine, and document whether adjustments are needed to:

1. The staffing plan established pursuant to paragraph (a) of this section;
2. The facility's deployment of video monitoring systems and other monitoring technologies; and
3. The resources the facility has available to commit to ensure adherence to the staffing plan.

#### **115.14 YOUTHFUL INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

##### **Youthful Offenders are not housed at Cremer.**

Agency policy D1-8.13 prohibits the placement of youthful offenders in a housing unit in which they would have sight, sound, or physical contact with any adult offender through the use of a shared dayroom or other common space, shower area, or sleeping quarters. CTCC however, does not house youthful offenders. Upon review of available policy and documentation and in speaking with CTCC reception staff, it was derived that if a youthful offender arrives in intake, they are directly supervised by custody staff through the entirety of the intake process and are normally routed to Farmington Correctional Center the same day.

In assessing the compliance at the agency level, auditors noted that State of Missouri regulation, Chapter 217 Department of Corrections Section 217.345, prohibits the placement of youthful offenders with adult offenders and requires physical separation and separate housing units. Institutional Services Procedure Manual, IS5-1.1 Diagnostic Center Reception and Orientation, outlines the procedure for notification, transportation, and housing of youthful offenders in the event one is admitted. Institutional Services Procedure Manual, IS5-3.1 Offender Housing Assignments, states, "youthful offenders will only be housed with other youthful offenders (standard operating procedures (SOP) will be developed to specify how such housing assignments will be made)."

#### **115.15 LIMITS TO CROSS GENDER VIEWING AND SEARCHES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy IS20-1.3 addresses sections (a), (d), (e) and (f) in regard to offender searches. Section (b) is N/A due to the fact that CTCC does not house female offenders. Documentation provided under (a) advised that "CTCC didn't conduct any cross-gender strip searches or cross-gender body cavity searches" during the 12 -month reporting period reviewed. Furthermore, MDOC staff does not conduct body cavity searches.

Agency policy D1-8.13 and CTCC policy SOP D1-8.13 mandates the announcing of opposite gender staff. These announcements are made once per shift and are documented in the custody staff chrono log. Both agency and facility policy dictate that offenders will be provided privacy from being viewed by non-medical opposite gender staff when "showering,

performing bodily functions and dressing” with the exception of exigent circumstances or “incidental to routine cell checks.” A DAI directive addressed to all “Wardens” was reviewed by the audit team which discussed the installation of privacy screens/barriers. Supplemental to the aforementioned memo from DAI, CTCC Warden also issued a directive to facility staff advising that shower curtains had been installed as privacy barriers to the main entrance of the showers rooms on the 2nd and 3rd floor. Per this directive and in compliance with PREA standard 115.15 (d), female staff are only allowed to pass beyond the curtain in exigent circumstances. The audit team observed said barriers during the tour. During the inmate interviews, all that were asked stated that they feel they have a reasonable expectation of privacy and alluded to confirmation of compliance of provision 115.15 (d).

Supporting documentation provided under 115.15(e) included an excerpt from policy D1-8.13 and IS11-34.1 “Health Assessment and Physical Examination at Reception”. Per D1-8.13, “If the gender of the offender is unknown at the time of intake, staff members shall not search the offender for the sole purpose of determining the offender's genital status. Genital status may be determined during conversations with the offender, reviewing medical records, or if necessary, through a broader medical examination conducted in private by the appropriate health care staff.”

Training curriculum on “Searches” is in place at CTCC and a corresponding lesson plan was reviewed by the audit team. The MDOC standard for searching transgender and intersex offenders is defined as search practices for cross-gender pat downs. Policy IS20-1.3 states that “when pat searching a transgender male offender, male staff will utilize the female search technique when searching the offender’s upper torso. If the gender of the offender is unknown, a female staff member will be assigned to perform the pat search.” Information provided in the PAQ as well as a memo (dated 12-2-14) from CTCC Chief of Security reported that as of 11-26-14, all facility staff had completed the new training curriculum for searches; including conducting searches of cross-gender, transgender and intersex inmates appropriately. Newly hired officers will receive this instruction during basic training.

<b>115.16</b>	<b>INMATES WITH DISABILITIES AND INMATES WHO ARE LIMITED ENGLISH PROFICIENT</b>
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- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

MDOC has established procedures, in policy D1-8.13, for disabled and limited English proficient offenders to benefit from all aspects of their PREA efforts. PREA brochures and acknowledgment forms are available in several languages and posters are available in English and Spanish. There is also a brochure available in Braille for blind offenders. As part of the orientation process, the NIC “Speaking Up” video is used along with its written transcript. CTCC SOP D5-5.1 “Deaf and Hard of Hearing Offenders” details where and how to seek such services and is also posted throughout the facility.

<b>115.17</b>	<b>HIRING AND PROMOTION DECISIONS</b>
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- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

MDOC policy D1-8.13 as well as facility policy SOP D1-8.13 prohibits the hiring or promoting of anyone that has engaged in sexual abuse with an offender in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual activity by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse. These policies also mandate the consideration of sexual harassment in determining whether to hire or promote.

MDOC policy D2-2.2 (Background Investigations) outlines all elements required for background investigations of all staff members. An extensive background investigation including a criminal records check utilizing the Missouri Uniform Law Enforcement System (MULES) and the National Criminal Information Center (NCIC) system is enforced. CTCC conducts annual background checks on employees in conjunction with their birth month. These checks are conducted by an administrative assistance who then forwards to the Warden for review and signature. Examples of employee MULES/NCIC checks were provided to the audit team for review.

In regard to 115.17 (c), CTCC provided the following advisement: “CTCC does not have our own personnel office. FRDC Personnel office staff conducts the checks for CTCC applicants who have previous experience working in institutional settings for information on substantiated allegations of sexual abuse or any resignations during a pending investigation of an allegation of

sexual abuse."

Policy also specifies, for promotions and other appointments, noting; "a check will be conducted on the active employee through Central Office Human Resources to inquire if there has been any formal discipline for sustained allegation(s) of sexual abuse and/or harassment of an offender or resident. All sustained allegations will be considered by the department before an employee is promoted or considered for other appointments."

Agency and facility policy (D1-8.13 and D2-2.2) as well as the employment application advise that material omissions are grounds for termination and address the contacting of previous institutional employers. MDOC Department Procedure Manual D2-11.14 Annual Employment Requirements asserts that criminal history checks are conducted annually, in the month following each staff member's birth month.

CTCC is able to provide information on official charges of sexual abuse or sexual harassment involving a former employee (as it would be a public record). However, they would be prohibited from providing information on sustained administrative cases unless written consent of the former employee was obtained (per MDOC policy D2-5.1-Maintenance of Employee Records).

During the reporting period, CTCC had 12 new hire employees; of which 11 had background checks. Employee files were reviewed at random; those reviewed contained records of background checks and auditors were also provided examples of contractor/volunteer background checks as well. Documentation of promoted employees also contained internal inquiries regarding misconduct involving sexual abuse or sexual harassment.

#### **115.18 UPGRADES TO FACILITIES AND TECHNOLOGY**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency procedure D4-4.8 –Security Camera Operations adheres to the elements of PREA standard 115.18 (b).

CTCC reported that there were no substantial expansions or modifications during the reporting period. According to CTCC's 2013 PREA Annual Report, CTCC had a total of three reported sexual abuse allegations; 2 were noted as "offender on offender" and one was listed as "employee on offender." All of these allegations were concluded as "not sustained." CTCC noted that in review of the 2013 sexual abuse incidents there was sufficient camera footage available, as all occurred in offender living area locations where there are currently cameras.

There were no PREA cases (sexual abuse or sexual harassment) reported in 2014 according to the PREA Annual Report provided in audit documentation.

As of late October 2014, 1 new DSSRV-004DVD-US system with support equipment was purchased and installed. Current cameras have been hooked up to the new DVR system. During the interview with the Warden, she advised that 6 cameras had been purchased during the past year and that maintenance staff were planning to install them in the "Phase 3" rooms in the near future. Additionally, using canteen funds, another new DSSRV-004DVD-US with support equipment, plus 3 extra cameras for the canteen and a monitor were purchased. CTCC Warden noted during the interview that the new system now has 30-day retention/record time which is a significant improvement from past capabilities.

#### **115.21 EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

MDOC Procedure D1-8.8 Evidence Collection, Accountability and Disposal provides a detailed outline of the agency's uniform evidence protocol which appears to be in line with "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents." Interviews of investigative staff as well as random and specialized staff indicated the application of this protocol. Knowledge of evidence collection and securing the crime scene was consistent throughout staff interviews.

All forensic exams are conducted off site by SANE's and agency policy D1-8.13, Section G. Health Services Care, delineates the

protocol thereof. CTCC noted that they have “had no out counts for forensic exams in the last 12 months.” The examples of forensic exams provided were from other MDOC facilities. A victim advocate is offered at the hospital (in Columbia, Mo), to accompany the offender through the exam process. This is offered in part, as a result of the development of a Weekly Rotation schedule shared between different chaplains who serve as victim advocates. Off-site advocacy training was provided and documentation indicates that all chaplains currently being utilized have received the necessary training.

#### **115.22 POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

CTCC and the MDOC have policy and protocol in place to ensure that an investigation is completed for all allegations of sexual abuse or sexual harassment which is mandated by agency policy D1-8.13 and facility policy SOP D1-8.13. There were no allegations during the 12-month reporting period. Policy requires that all sustained investigations are referred for prosecution and the PREA Coordinator has a tracking system for each referral and account of each case’s status referral status.

MDOC has a PREA link on their website under “Resources.” From this link, annual aggregated sexual abuse data can be viewed as well as an overview of PREA, the agency’s zero-tolerance policy, third party reporting information, and other relevant resources such as the PREA Resource Center and Just Detention International.

#### **115.31 EMPLOYEE TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Required training elements of 115.31(a) were reviewed by auditors in the training curriculum that has been in use during the reporting period. During the reporting period, 80 new staff were hired; all of which received the training. MDOC policy D1-8.13 mandates initial PREA training upon hire and then refreshers every two years. In the off-year, between refreshers, policy states; “the department’s training staff members shall provide current information on sexual abuse and sexual harassment policies.”

In addition, if a staff member is reassigned or is transferred from a facility that houses female offenders to a facility that houses male offenders (or vice versa), agency and facility policy D1-8.13 requires staff to receive gender specific training as part of their orientation process.

Training records of new staff members as well as long time staff were provided for review. Records of initial PREA training were found in employee files as well as documentation of refresher training completed online. Training records reviewed and signed acknowledgement sheets provided documentation that staff had received and understood the training.

#### **115.32 VOLUNTEER AND CONTRACTOR TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy and facility SOP D1-8.13 mandates training for volunteers and contractors congruent with that of training for all staff members. MDOC’s definition of staff member includes volunteers and contractors. Auditors reviewed the lesson plan for “Volunteers in Corrections Training” which contains information about MDOC’s zero tolerance policy as well as the definitions of sexual abuse and sexual harassment, red flags of offender-on-offender sexual abuse, and reporting requirements. Volunteers and contractors are provided a brochure which reiterates the information provided in training. All volunteers and contractors interviewed reported that they had received PREA training. Signed acknowledgment forms were provided in the audit documentation.

#### **115.33 INMATE EDUCATION**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

All offenders are offered PREA education upon arrival to CTCC. MDOC utilizes the Speaking Up video, PREA brochures, and posters visible throughout the facility. During the 12-month reporting period, CTCC reported providing PREA orientation to 677 offenders upon intake to the facility. Additionally, comprehensive education was provided to 752 offenders within 30 days of arrival. PREA posters also hang in the hallway where new offenders sit while they are being processed in that explains how to report sexual abuse/harassment.

It was noted that new offender intake screening is completed by the corrections case manager the day offenders are transferred to CTCC. Documentation explained that there was a period of time up until December of 2014 (and shortly thereafter) that inmates were being informed of the zero tolerance policy and ways to report sexual abuse/harassment during the intake process, however it was not being documented. This was missed in part, due to the retirement of a former staff member, and the transition of a new case manager. Documentation advised that "to ensure that this aspect is not missed again and also to document that it is occurring, on 2/11/15 it was added to the CTCC Classification Screening and Intake Checklist that gets completed by the corrections case manager while meeting with each new offender."

A statewide directive from the Agency Director of Adult Institutions was issued in August 2012 to all wardens regarding the requirements of offender PREA education.

As noted in 115.16 comments, offender education is available in a variety of formats and is accessible to offenders who are limited English proficient, deaf, visually impaired, or are otherwise disabled.

Auditors reviewed the offender PREA material and noted that pertinent information was contained therein; (i.e. offenders right to be free from sexual abuse and sexual harassment, avenues of reporting, zero tolerance policy). Auditors also reviewed samples of offender acknowledgment forms. Posters were visible in all areas of the institution and offenders reported consistently throughout the interviews that they understood avenues of reporting and their right to be free from sexual abuse and sexual harassment.

**115.34 SPECIALIZED TRAINING: INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

D1.8.13 Offender Sexual Abuse and Harassment mandates annual specialized training for investigative staff. "All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training by the designated inspector general's office staff members". The 6 module, 36 hour training course was reviewed by auditors along with a log of staff completing the training that indicates the 2 investigators assigned to FRDC have completed the required training. CTCC does not have an assigned investigator. When an investigator is needed one is assigned from another facility. Frequently it is the investigator from FRDC but it could sometimes be from other locations based on workload.

**115.35 SPECIALIZED TRAINING: MEDICAL AND MENTAL HEALTH CARE**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

D1.8.13 Offender Sexual Abuse and Harassment mandates annual specialized training for medical and mental health staff. This specialized training is four hours in length and contains the required elements of 115.35 along with relevant scenarios and group activities.

Forensic exams are not conducted at CTCC.

**115.41 SCREENING FOR VICTIMIZATION AND ABUSIVENESS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)



☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

D1.8.13- Offender Sexual Abuse and Harassment policy: "Adult Internal Risk Assessment: An instrument utilized to assess offenders during intake screening and upon transfer to another facility for their risk of being sexually abused by other offenders or sexually abusive towards other offenders". The following is excerpt from policy:

**C.RECEPTION AND ORIENTATION:**

1. a. Offenders shall be assessed within 72 hours of arrival.

b. Offenders shall be reassessed within 30 days of arrival.

(1) The reassessment shall consider additional relevant information received by the facility after the initial intake screening.

c. The offender's risk level shall be reassessed when warranted due to a referral, incident of sexual abuse, or upon request or receipt of additional information that impacts an offender's risk of sexual victimization or abusiveness.

d. The offender shall not be disciplined for refusing to answer or not disclosing complete information during the assessment. Institutional Services procedure IS5-2.3 Offender Internal Classification: also requires the 72 hour and 30 day assessment.

Number of offenders received during this 12 month period: 789

Number of offenders received during this 12 month period whose length of stay was 30 days or more: 739

Number of offenders received during this 12 month period whose length of stay was 72 hours or more: 781

In practice all inmates are screened on the date of arrival and interviews with assigned staff indicate a clear understand and adherence to policy and procedure.

**115.42 USE OF SCREENING INFORMATION**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

MDOC procedure IS18-1.1 Required Activities, which in part states, "Housing unit staff members will utilize the internal classification information to designate required activities assignments for the purpose of keeping separate and/or ensuring the appropriate monitoring of those offenders at high risk of being sexually victimized from those at high risk of being sexually abusive when working or attending programming together in accordance with institutional services procedures regarding offender internal classification."

CTCC reported that have had no transgender offenders during the 12 months prior to the audit. MDOC has created a Transgender/Intersex Committee that is charged with making the housing decisions of transgender or intersex offenders, which, "shall not be made based solely on genitalia but must consider the offender's health and safety and the security of the facility." MDOC procedure IS5-3.1 Offender Housing Assignments requires that, as part of the duties of a facility's Transgender Committee, that it "will review the housing assignments every 6 (six) months" and that transgender or intersex offenders will be given the opportunity to shower separately in accordance with a facility's SOP.

Use of the risk assessment outcomes for housing and job assignments is very apparent and staff interviews confirmed that staff are aware of the requirements for assessment and use of the "Alpha", "Kappa", and "Sigma" indicators when assigning jobs and housing

Since 8/20/12, there have been no offenders that indicated they were transgender or intersex that have been housed at CTCC.

**115.43 PROTECTIVE CUSTODY**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

CTCC does not have Administrative Segregation, due to all offenders placed at CTCC must be able to remain in general population in order to participate in the ITC substance abuse treatment program.

If an offender were to be assessed as needing protective custody due to being at risk of sexual victimization, he could temporarily

be placed in TASC for protective custody needs but then would need to be transferred to another location for placement in segregated housing.

If an offender were assessed as not needing protective custody but needing to be housed somewhere other than CTCC, a transfer to BTC (the Boonville Treatment Center) could be arranged.

There were no offenders placed in TASC for this reason during the 12 month reporting period: March 1, 2014-February 28, 2015.

<b>115.51</b>	<b>INMATE REPORTING</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.17: REPORTING SEXUAL ABUSE OR HARASSMENT**

1. Each facility's CAO or designee shall provide multiple ways for offenders to make anonymous reports of allegations of offender sexual abuse and harassment, retaliation, staff neglect, and violation of responsibilities that may have contributed to an incident of offender sexual abuse, to include but not be limited to:

- a. informal resolution request (IRR), grievance process, or offender complaint,
- b. to a staff member,
- c. PREA hotline,
- d. advocacy agency,
- e. Department of Public Safety, Crimes Victims Services Unit

Auditors found posters throughout the facility with contact information for the above noted reporting types. During offender interviews it was apparent that inmates trust that they can report sexual abuse or harassment to staff. Staff interviews indicated that they accept reports from offenders in writing and from third parties, and that they would treat any reports in the same manner and according to the coordinated response protocol.

Offenders are not detained at CTCC for civil immigration purposes.

Auditors reviewed an MOU between MDOC and the Department of Public Safety in which responsibilities of each entity was outlined in the event that an allegation of sexual abuse or sexual harassment is received. The entities have established a Sharepoint application as a mutually accessible access point for each to share and refer allegations. This was established in July 2013.

The offender PREA brochure and employee handbook were provided to auditors.

<b>115.52</b>	<b>EXHAUSTION OF ADMINISTRATIVE REMEDIES</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 specify that there is no limit imposed on offender sexual abuse grievances, that they can be submitted to a staff member who is not the subject of the grievance, and that there is no informal resolution required.

N. Policy D5-3.2 PREA INFORMAL RESOLUTION REQUEST/GRIEVANCE/APPEAL:

1. The department shall not impose a time limit on when an offender may submit a complaint regarding an allegation of offender sexual abuse.

- a. The department will not require an offender to use the informal grievance process, or to otherwise attempt to resolve with



staff members, an alleged incident of offender sexual abuse.

2. All informal resolution requests, offender grievances or offender grievance appeals containing allegations of offender sexual abuse, will be processed in the manner outlined in this section.

a. An offender who alleges offender sexual abuse may submit an informal resolution request, offender grievance, or offender grievance appeal without submitting it to a staff member who is subject to the complaint.

b. A staff member who is the subject of the complaint should not be the respondent.

3. When the staff member responsible for processing informal resolution requests, offender grievances, or offender grievance appeals receives a complaint alleging offender sexual abuse, a copy of the form will be forwarded to the shift commander and the offender sexual abuse coordinated response will be initiated in accordance with the department procedure regarding PREA.

4. Informal resolution request alleging sexual abuse will be processed normally with the exception of the following:

a. A response should be completed as soon as practical, but no later than 30 calendar days of receipt.

5. Offender grievances alleging sexual abuse will be processed normally with the following exceptions:

a. the CAO or designee should respond within 30 calendar days of receipt.

b. Computation of the 30 day time period will not include the days between the offender's receipt of the informal resolution request and receipt of the offender grievance by the grievance officer or designee.

6. Offender grievance appeals alleging offender sexual abuse will be processed normally with the following exceptions:

a. a response should be provided as soon as practical, but no later than 30 calendar days of receipt.

b. Computation of the 30 day time period will not include the days between the offender's receipt of the offender grievance response and receipt of the offender grievance appeal by central office grievance staff members. Appeals will be referred to the deputy division director or designee.

c. An extension of time to respond, of up to 70 days, may be claimed if the normal time period for response is insufficient to make an appropriate decision.

(1) The offender will be notified in writing of any such extension and will be provided a date by which a response will be provided.

d. At any level of the administrative process, including the offender grievance appeal level, if the offender does not receive a response within the time allotted for reply, including any properly noticed extension, the offender may proceed to the next level of the offender grievance process.

7. Third Party Reporting: Third parties, including fellow offenders, staff members, family members, attorneys, and outside advocates, shall be permitted to assist offenders in filing requests for informal resolution requests, grievances or appeals relating to allegations of offender sexual abuse. This assistance cannot interfere with the safety and security of the institution.

a. When a staff member receives a request from a third party to file a complaint via the offender grievance procedure on behalf of an offender regarding allegations of offender sexual abuse. The staff member will require the party making the complaint to submit such in writing.

b. Administrative or case management staff members will then prepare a report of incident in accordance with procedure for possible investigation or inquiry.

c. When a staff member receives the documentation from the reporting third party, it will be attached to an informal resolution request form and will immediately be recorded in accordance with this procedure. A copy of the documentation will also be forwarded to the CAO or designee in order to be attached to the possible investigation or inquiry.

d. The case manager shall attempt to discuss the issue with the offender (victim) prior to developing a response to confirm if the alleged victim agrees to have the request filed on his behalf.

e. If the offender declines to have the request process on his behalf, the case manager shall document the offender's decision in

the discussion section of the informal resolution request form and the complaint shall be considered withdrawn for grievance purposes.

f. If the offender agrees to have the request processed on his behalf, it will then be documented in the discussion section of the informal resolution request and will be processed normally in accordance with this procedure.

8. Nothing in this section shall restrict the agency's ability to defend against an offender lawsuit on the ground that the applicable statute of limitations has expired.

**O. PREA – EMERGENCY INFORMAL RESOLUTION REQUESTS:**

1. Allegations of offender sexual abuse by employees shall immediately be reported to the CAO or designee for possible investigation or inquiry.

2. If the staff member who processes the informal resolution requests determines that it meets the definition of a PREA emergency complaint, the offender will be provided an informal resolution request form.

3. Emergency informal resolution requests will be processed as follows:

a. The offender will request an informal resolution request form from case management staff members and briefly state the issues and subject of complaint in accordance with this procedure.

b. When a staff member receives the completed informal resolution request form from the offender, the staff member will record receipt of the form in accordance with this procedure and it will be taken to the CAO or designee immediately.

c. Upon receipt of an informal resolution request from an offender, the CAO or designee may confer with the PREA site coordinator to make the determination if the informal resolution request should be handled as an emergency.

d. The CAO or designee will prepare an initial response which will be attached to the informal resolution request and provided to the offender within 48 hours of receipt of the initial filing date. The offender will sign and date the response.

e. A final response from the CAO or designee will be provided to the offender within 5 calendar days from the initial filing date. The offender will sign and date the form.

f. The initial and final response for the informal resolution request shall document the department's determination whether the offender is in substantial risk of imminent sexual abuse and the action taken in response to the emergency informal resolution request.

g. If the offender is unsatisfied with the final response for the informal resolution request and chooses to file a grievance, an offender grievance form will be provided. The grievance or grievance appeal will then be processed as a non-emergency PREA complaint as noted in this procedure.

There were no IRR's or grievances regarding PREA issues (sexual abuse or harassment) filed at CTCC in the past 12 months, 3/01/14-2/28/15.

<b>115.53</b>	<b>INMATE ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES AND LEGAL REPRESENTATION</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
|--|

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.53

Policy D1.8.13 Offender Sexual Abuse and Harassment (pg 21)

6. Facilities shall make available to offenders mailing addresses, telephone numbers, including toll-free hotline numbers where available of local, state, or national victim advocacy or rape crisis organizations.

a. The facility shall enable reasonable communication between offender victims and these organizations.

b. A list of the above shall be maintained in the library and/or other common areas of every facility.

The facility has tried to secure MOU with local advocacy center True North Crisis Center and the center declined to enter an agreement or provide services. The following information is found on posters throughout the facility for outside support:

Just Detention International  
3325 Wilshire Blvd., Suite 340  
Los Angeles, CA 90010  
213-384-1400

To call this number, you will need to utilize the offender telephone system.

Rape, Abuse and Incest National Network (RAINN)

1220 L Street NW, Suite 505

Washington DC 20005

To call this agency, you may dial 7246 on the offender telephone system at no charge.

#### **115.54 THIRD-PARTY REPORTING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Methods to report sexual abuse and harassment are made available to the public via the Department's website which you can access at <http://doc.mo.gov/OD/PREA.php>.

#### **115.61 STAFF AND AGENCY REPORTING DUTIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 outlines compliance with Standard 115.61.

further, State Statute : Abuse of offender, duty to report, penalty--confidentiality of report, immunity from liability--harassment prohibited. 217.410.

Policy D1-8.13 excerpt:

6. The CAO or designee shall control the dissemination of sensitive information related to offender sexual abuse to ensure the offender is not exploited by staff members or other offenders.

7. Failure to report offender sexual abuse is a class A misdemeanor. All staff members, volunteers, and contractors shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility and any knowledge of retaliation against offenders or staff members who reported such an incident and any staff member neglect or violation of responsibilities that may have contributed to an incident or retaliation in accordance with this procedure.

a. Medical and mental health staff members shall inform offenders of the practitioner's duty to report at the initiation of services.

8. Staff members are prohibited from revealing any information related to an allegation of offender sexual abuse or harassment other than to the extent necessary to make treatment, investigation, and other security and management decisions.

#### **115.62 AGENCY PROTECTION DUTIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 outlines compliance with Standard 115.62.

All staff interviewed, as well as the Agency Head and Warden, reported they would take immediate action if they learned an offender was subject to a substantial risk of imminent sexual abuse.

In the past 12 months, there have been no reports or determinations that an inmate is subject to a substantial risk of imminent

sexual abuse.

If a report or determination was made that an inmate is subject to a substantial risk of imminent sexual abuse, we would assess the offender for least restrictive housing. This should be done within 24 hours. If the offender requested protective custody he would be housed in TASC until transfer arrangements could be made.

If the offender did not want protective custody, some other alternatives would be to move him to the second floor (sigma floor) or arrange to transfer him to the Boonville Treatment Program.

#### **115.63 REPORTING TO OTHER CONFINEMENT FACILITIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

In the past 12 months, CTCC has not had any offenders report allegations of being sexually abused while housed within another confinement facility.

If an allegation of this nature were to be made, the shift supervisor would complete the coordinated response. If the alleged incident happened at another MDOC facility the normal notification process would be utilized. If the alleged incident happened while in a county jail, it would be forwarded to the DOC PREA coordinator at central office.

Excerpt from December staff memo outlining changes to policy with regard to 115.63:

There has been a recent change to D1-8.13 Offender Sexual Abuse and Harassment policy. Previously, when an offender reported a PREA incident that occurred at another department such as a jail or federal facility we did not have to do the Coordinated Response form. We only had to notify Mental Health staff who would follow up with the offender. The new policy that went into effect on 12/26/14 has changed that procedure. The new policy now reads:

2. Upon receiving information that an offender has been sexually abused while assigned at another facility the coordinated response for offender sexual abuse will be immediately initiated as outlined in this procedure. If the alleged abuse occurred at a facility outside the Missouri Department of Corrections, the notification checklist will be forwarded to the department's PREA coordinator. The PREA coordinator will ensure notification to the facility is made with 72 hours.

a. A coordinated response will be initiated as outlined in this procedure for all allegations of offender sexual abuse that are received from facilities outside the Missouri Department of Corrections.

Whenever an offender discloses that they have had a PREA incident at another facility or agency, have the shift commander fill out the form. They only need to forward it to me and I will take care of notification to the PREA Coordinator. They also need to summarize the event in the comment section and also if the offender reported the incident or not at the time and if so, who they reported it to.

#### **115.64 STAFF FIRST RESPONDER DUTIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D 1 8.13 dictates compliance with Standard 115.64

There have been no allegations made at CTCC in the last 12 months.

CTCC has a coordinated response protocol which outlines duties of first responders which includes; separating the alleged victim, preserving and protecting the crime scene and taking measures in regards to the victim to preserve physical evidence.

Pages 21-23 of staff basic training cover these requirements.

Staff members interviewed were able to clearly explain their duties relative to the coordinated response protocols.

#### **115.65 COORDINATED RESPONSE**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

<p>“Coordinated Response to Offender Sexual Abuse” is CTCC's written institutional plan of coordinated actions in the case of offender sexual abuse. This plan accounts for coordination among staff first responders, medical and mental health staff, investigators, and facility leadership which contains very detailed direction distinguishing the duties of each staff member. The “Coordinated Response to Offender Sexual Abuse” is a five-page handout that outlines immediate response on the floor for first responders, supervisors, medical, mental health, investigators, PCM, and PREA Coordinator. The PREA training lesson plan also clearly outlines these actions, to be taken by staff in the event of sexual abuse of an offender.</p>	
<b>115.66</b>	<b>PRESERVATION OF ABILITY TO PROTECT INMATES FROM CONTACT WITH ABUSERS</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Policy D2-11.6 Labor Organizations meets requirements of Standard 115.66.</p> <p>CTCC did provide the agreement between The Department of Corrections State of Missouri and The Missouri Corrections Officers Association (MOCO). The agreement is valid from 10/1/2014 to 9/30/2018.</p>	
<b>115.67</b>	<b>AGENCY PROTECTION AGAINST RETALIATION</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 contains the elements of Standard 115.67.</p> <p>The policy states the PREA Site Coordinator is responsible for monitoring retaliation.</p> <p>The policy dictates multiple measures shall be employed as means of protection for staff and offenders who fear retaliation for reporting an incident of sexual abuse or sexual harassment.</p> <p>The policy dictates monitoring shall occur for a minimum of 90 days. The policy also dictates monitoring would continue for an additional 90 days or until the victim or the reporter are no longer in fear of retaliation or the investigational inquiry disposition was unfounded.</p> <p>The items monitored are those listed in the elements of this standard. CTCC utilizes an Assessment/Retaliation checklist to document monitoring efforts.</p> <p>The policy dictates periodic status checks are completed every 30 days.</p> <p>The policy dictates any individual who cooperates with an investigation and expresses fear of retaliation; the facility will take appropriate measures to protect the individual from retaliation.</p> <p>The policy dictates monitoring will conclude when it is determined the allegation is unfounded.</p> <p>CTCC provided examples of monitoring incidents as supporting documentation. The facility only houses inmates for treatment and the program is for 84 days so the examples were only for initial or 30 day follow-up but they showed they are following the procedures.</p>	
<b>115.68</b>	<b>POST-ALLEGATION PROTECTIVE CUSTODY</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.68.</p>	

The policy dictates offenders at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives have been made.

The policy dictates the facility shall review the offender's status every 30 days to determine the need for continued segregation.

The policy does not address or provide for what privileges, access to programs and work opportunities are available to offenders placed in involuntary segregation or if it is documented what access has been limited, the duration of any limitation, or the reason(s) they are limited.

Auditors reviewed investigation reports, documentation and also spoke with shift supervisors and both show that CTCC considers alternatives to involuntary segregation in accordance with standard 115.43.

<b>115.71</b>	<b>CRIMINAL AND ADMINISTRATIVE INVESTIGATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D 1-8.1 and D 1-8.4 dictate compliance with Standard 115.71.

CTCC's investigation division is under the jurisdiction of the Inspector General's Office. CTCC uses an investigator from FRDC who maintains specialized training in sexual abuse investigations. Investigators conduct administrative and criminal investigations.

Investigators are trained to collect and preserve evidence, interviewing, report writing and continuing an investigation to prosecution when warranted. Investigation reports are well documented and are maintained by the agency. Both policy and practice supported that all sustained cases were referred for prosecution. The PREA Coordinator has a tracking system which accounts for each referral and the status thereof.

CTCC provided investigations for pre-audit review as supporting documentation which included examples of investigation request and examples of third party reports. Auditors also reviewed investigation files on-site. Investigations reviewed indicated they were done in a prompt, thorough and objective manner. CTCC did not have any sustained allegations of offender sexual abuse therefore there were no referrals for criminal prosecution.

Examples were from other agency facilities.

The agency investigator from FRDC interviewed was able to articulate elements of this standard and provided elements of agency training and investigations protocol. The investigator interviewed was also able to articulate procedures for counseling with prosecutors and outside law enforcement agencies.

<b>115.72</b>	<b>EVIDENTIARY STANDARDS FOR ADMINISTRATIVE INVESTIGATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility does not employ a standard higher than a preponderance of evidence as proof in determining whether allegations of sexual abuse or sexual harassment are substantiated. Review of the investigations supported this as practice.

<b>115.73</b>	<b>REPORTING TO INMATES</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility compliance with Standard 115.73.	
The policy dictates, upon the conclusion of an investigation, the facility informs the offender whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.	
115.73(b) is not applicable to this audit.	
The policy dictates that following an allegation involving staff-on-offender sexual abuse, (unless determined to be unfounded) the facility informs the offender when; the staff member is no longer posted within the offender's living unit, the staff member is no longer employed at the facility, the agency learns the staff member has been indicted on a charge related to sexual abuse, or the agency learns the staff member has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing this offender notification.	
The policy dictates that, following an offender's allegation he/she has been abused by another offender, the facility informs the alleged victim when; the agency has learned the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or the agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing the notification to the offender.	
The policy dictates the notifications shall be done in writing.	
CTCC has not had any PREA allegations/investigations in the past 12 months	
<b>115.76</b>	<b>DISCIPLINARY SANCTIONS FOR STAFF</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 and Policy D2-11.10 dictate compliance with Standard 115.76.	
The policy dictates staff is subject to disciplinary sanctions up to and including termination for violations of agency sexual abuse or sexual harassment policies.	
The policy dictates termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse.	
Policy D2-11.10 Staff Member Conduct addresses incidents of staff misconduct of a sexual nature and includes sexual abuse and harassment of offenders.	
Policy D1-8.13 dictates terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.	
Review of investigations indicated that staff are disciplined for violating the agency sexual abuse and sexual harassment policy. CTCC reported there were no incidents to report to relevant licensing bodies during this audit period.	
<b>115.77</b>	<b>CORRECTIVE ACTION FOR CONTRACTORS AND VOLUNTEERS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 dictates compliance with Standard 115.77.	
The policy dictates contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement and relevant licensing bodies.	
The policy further dictates the facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in cases of any other violations.	
Policy D2-13.1 Volunteers addresses conduct pertinent to volunteers and dictates any allegation of sexual abuse or sexual	

harassment will be referred for investigation.	
CTCC reported there were no incidents involving a contractor or volunteer to report to law enforcement or relevant licensing body during this audit period.	
<b>115.78</b>	<b>DISCIPLINARY SANCTIONS FOR INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 dictates compliance with Standard 115.78.</p> <p>The policy dictates offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding the offender engaged in offender-on-offender sexual abuse.</p> <p>The policy dictates sanctions shall be commensurate with the nature of and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories.</p> <p>The policy dictates an offender's mental disability or mental illness contributed to his behavior when determining sanction(s).</p> <p>The policy dictates if found guilty, the offender shall be referred for appropriate treatment to include therapy or counseling by mental health staff.</p> <p>The policy dictates an offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent.</p> <p>CTCC provided MDOC Conduct and Rules Sanctions IS19-1.1 addressing consensual and non-consensual sexual activity of offenders.</p> <p>CTCC provided a facility directive/memo which details considerations for mental disability or mental illness of offenders in conjunction with the offender disciplinary process. CTCC also provided a referral form utilized by MDOC for input/feedback from a qualified mental health practitioner in sustained cases of offender on offender sexual abuse.</p>	
<b>115.81</b>	<b>MEDICAL AND MENTAL HEALTH SCREENINGS; HISTORY OF SEXUAL ABUSE</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy IS11-32 Receiving Intake Unit and D1-8.13 Offender Sexual Abuse and Harassment address compliance with Standard 115.81.</p> <p>Both policies dictate that if an offender discloses victimization or perpetration of sexual abuse whether it occurred in an institutional setting or in the community, staff offer a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The Adult Internal Risk Assessment (PREA screening) documents whether a mental health referral was accepted or declined and, if accepted, prompts staff to complete the mental health referral.</p> <p>Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments or as otherwise required by state or local law.</p> <p>Both policies dictate medical and mental health practitioners shall obtain informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18.</p> <p>CTCC also provided medical and mental health PREA event logs and offender confinement records as supporting documentation for this standard.</p>	
<b>115.82</b>	<b>ACCESS TO EMERGENCY MEDICAL AND MENTAL HEALTH SERVICES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)	



<input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <p>Agency policy D1-8.13 addresses compliance with Standard 115.82.</p> <p>The policy dictates that offenders shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The scope of such services is to be determined by medical and mental health practitioners according to professional judgment. Documentation and specialized staff interviews supported this as practice.</p> <p>The policy dictates that offender victims of sexual abuse while incarcerated shall be offered timely information about and time access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate.</p> <p>The policy dictates services will be provided to the victim without financial cost whether the victim names the abuser or cooperates with the investigation.</p> <p>CTCC utilizes CORIZON as the medical provider and provided Part 2.4 of the contractual agreement between CTCC and CORIZON as supporting documentation denoting CORIZON's obligation to provide medical and mental health services to CTCC offenders in compliance with the PREA Standards.</p> <p>The same contractual agreement denotes in the Offsite Hospital Care section, CORIZON will be responsible for and will arrange timely payment for all hospital care and related health care expenses.</p> <p>Staff interviewed articulated facility practice and agency policy in regards to medical and mental health care provided in incidents of sexual abuse.</p>	
<b>115.83</b>	<b>ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <p>Agency policy D1-8.13 dictates compliance with Standard 115.83.</p> <p>CTCC offers medical and mental health evaluations and, as appropriate, treatment to all offenders who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.</p> <p>The policy dictates follow-up services shall be provided and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or release from custody.</p> <p>The policy and practice indicates that CTCC provides services consistent with the community level of care.</p> <p>The policy dictates victims of sexual abuse shall be offered prophylaxis for sexually transmitted infections.</p> <p>115.83(d), (e), do not apply as CTCC is an all-male facility.</p> <p>The policy dictates treatment services are provided without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation.</p> <p>The policy dictates an offender perpetrator of sexual abuse shall receive mental health evaluation by a qualified mental health practitioner within 60 days of learning of such abuse.</p> <p>CTCC has not had any referrals to show as examples of follow up care provided to offenders as supporting documentation for this standard.</p>	
<b>115.86</b>	<b>SEXUAL ABUSE INCIDENT REVIEWS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)	

<input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.86.</p> <p>The policy dictates CTCC shall conduct a sexual abuse incident review, or “debriefings,” at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation was determined to be unfounded. It is documented on the PREA sexual abuse debriefing form and submitted to the PREA Coordinator, Chief Administrative Officer, and assistant division director.</p> <p>The policy dictates such reviews shall be held within 30 days of a formal investigation, that the review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners, and that facilities shall implement the recommendations for improvement or document its reasons for not doing so.</p> <p>CTCC provided as supporting documentation a sample review which documented all elements of Standard 115.86(d) 1-6.</p> <p>Auditors concluded inclusive with supporting documentation provided by CTCC, staff interviewed articulated the importance of sexual abuse reviews and their relevance to enhance the safety of offenders and staff.</p>	
<b>115.87</b>	<b>DATA COLLECTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.87.</p> <p>The policy describes the collection of uniform data by the Agency PREA Coordinator. Data is collected and reported on BJS Survey of Sexual Violence in addition to maintaining data in the information network (COIN) system. Policy and practice indicated that data is collected annually, at a minimum.</p> <p>CTCC provided documentation of monthly incident based data for years 2013 and 2014, and the annual report by facility for 2013.</p> <p>115.87(e) does not apply to this audit.</p>	
<b>115.88</b>	<b>DATA REVIEW FOR CORRECTIVE ACTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 dictates compliance with Standard 115.88.</p> <p>The policy outlines the Agency PREA Coordinator’s responsibilities in collecting and aggregating data and preparing an annual report, pursuant to 115.88. Data was available and was reviewed by auditors on the agency’s website.</p> <p>Data is collected and used to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. Problem areas are identified and corrective actions are noted on an ongoing basis. The agency prepares an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.</p> <p>The report(s) compares data from previous years along with corrective actions and denotes the agency’s progress in addressing sexual abuse.</p> <p>The reports are submitted and approved by the agency head, the Agency PREA Coordinator, and are provided on the agency’s website. The website was reviewed by auditors and was found to be compliant with element(s) of this standard.</p> <p>The agency redacts specific material from reports when publication would present a clear and specific threat to the safety and</p>	

security of a facility. The agency indicates the nature of the material redacted.

CTCC provided the CTCC PREA yearly report for 2013 and the Missouri Department of Corrections yearly PREA report for 2013 as supporting documentation.

<b>115.89</b>	<b>DATA STORAGE, PUBLICATION, AND DESTRUCTION</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
|--|

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 and practice assert that data is securely retained. Data is available via website and can be viewed by the public. Personal information is redacted.

**AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of agency under review.



\_\_\_\_\_  
Auditor Signature

\_\_\_\_\_  
05/08/2015

Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

Name of facility:	<a href="#">Crossroads Correctional Center</a>	
Physical Address:	<a href="#">1115 East Pence Road Cameron, MO 64429</a>	
Date report submitted:	<a href="#">January 28, 2015</a>	
<b>Auditor Information:</b>	<b><a href="#">Mark A. Mora, Ron Baker</a></b>	
Address:		
E-Mail:	<a href="mailto:mark.mora@doc.ks.gov">mark.mora@doc.ks.gov</a> , <a href="mailto:ronb@doc.ks.gov">ronb@doc.ks.gov</a>	
Telephone number:	<a href="#">620-481-7273, 785-338-0971</a>	
Date of facility visit:	<a href="#">01/12/2015 - 01/14/2015</a>	
<b>Facility Information</b>		
Facility mailing address:	<a href="#">1115 East Pence Road Cameron, MO 64429</a>	
Telephone number:		
The facility is:	<input type="checkbox"/> Military <input type="checkbox"/> County <input type="checkbox"/> Federal <input type="checkbox"/> Private for profit <input type="checkbox"/> Municipal <input checked="" type="checkbox"/> State <input type="checkbox"/> Private not for profit	
Facility Type:	<input checked="" type="checkbox"/> Adult	
Name of PREA Compliance Manager:	<a href="#">Terry Page</a>	Title: <a href="#">Deputy Warden</a>
E-Mail Address:	<a href="mailto:Terry.Page@doc.mo.gov">Terry.Page@doc.mo.gov</a>	Phone Number:
<b>Agency Information</b>		
Name of agency:	<a href="#">Missouri Department of Corrections</a>	
Governing authority or parent agency: (if applicable)	<a href="#">State of Missouri</a>	
Physical address:	<a href="#">2728 Plaza Drive Jefferson City, MO 65109</a>	
Mailing address: (if different from above)		
Telephone Number:	<a href="#">573-526-9003</a>	
<b>Agency Chief Executive Officer</b>		
Name:	<a href="#">George Lombardi</a>	Title: <a href="#">Director</a>
E-Mail Address:	<a href="mailto:George.Lombardi@doc.mo.gov">George.Lombardi@doc.mo.gov</a>	Telephone Number: <a href="#">(573) 526-6607</a>
<b>Agency –wide PREA Coordinator</b>		
Name:	<a href="#">Vevia Sturm</a>	Title: <a href="#">PREA Coordinator</a>
E-Mail Address:	<a href="mailto:Vevia.Sturm@doc.mo.gov">Vevia.Sturm@doc.mo.gov</a>	Telephone Number: <a href="#">(573) 522-1634</a>

# AUDIT FINDINGS

## NARRATIVE:

The audit of the Crossroads Correctional Center (CRCC) was conducted on January 12-14, 2015 by Mark A. Mora and Ron Baker both certified auditors and one assistant in order to determine compliance with Prison Rape Elimination Act (PREA) standards.

Prior to the onsite portion of the audit, auditors provided the facility with the Auditor Notice which was posted at least 6 weeks prior to the onsite. The Pre-Audit Questionnaire along with other supporting documentation was provided to the auditors to review in advance of the onsite portion of the audit and was done so in a very organized and comprehensive manner. Correspondence between the auditors and the PREA Coordinator and PREA Compliance Manager occurred throughout the pre-audit phase, and the auditor submitted a tentative audit schedule to the facility prior to arrival.

The auditors reported to CRCC on 1/12/15 to initiate the onsite portion of the audit. An entrance meeting was conducted to introduce the audit team to the CRCC administration. Those in attendance included: Warden Ronda Pash, Deputy Warden Terry Page, Deputy Warden Chris McBee, Agency PREA Coordinator Vevia Sturm, Chief of Security Lauretta Aitkens, Custody Manager Amy Parkhurst, Captain Steven Brewer, Lt. Victor Clevenger and Security Administrator Casey Hansen.

Following the entrance meeting was a tour of the CRCC facility. Areas toured included the living units, offender services, offender dining room, recreation areas, visiting room, industries areas, case management offices and shift supervisor areas. Informal interviews were conducted with various staff and offenders during the tour.

Offender rosters were obtained and a random sample of offenders were chosen and interviewed. Offenders understood PREA and how to report an incident of sexual abuse and harassment. Information regarding a zero tolerance policy was easily accessible to the offender population.

Interviews were conducted with the Agency PREA Coordinator, Facility PCM, Warden, Human Resources, Health Services, Shift Supervisors, Security Staff, Counselors and investigators. Security Staff from all three shifts were interviewed. All staff were knowledgeable of CRCC and agency policy in regards to their responsibilities subsequent to a report of sexual abuse or harassment.

PREA investigation files were made accessible to the audit team to examine. Investigations are handled by investigators from the Inspector General's Office. Investigations are done promptly, thoroughly and are well documented.

PREA Standards and policies were reviewed for compliance. Questions were clarified and suggestions were made to enhance procedures. CRCC complied with all applicable standards.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The Crossroads Correctional Center is located at 1115 East Pence Road in Cameron, Missouri. CRCC is an all-male maximum security facility housing approximately 1400 offenders. The age range of offenders is 18-90 years of age. CRCC encompasses 13 buildings and was established in 1997. CRCC has an assigned staff of 398 total positions. CRCC does not house youthful offenders. CRCC maintains cameras

throughout the facility to enhance staff coverage.

CRCC provides programming, classification, and treatment to encourage individualized progression. CRCC provides offenders a number of detail assignments to include vocational programs. Recreational activities are available to all offenders.

The facility design allows for separation of offenders and or staff subsequent to an allegation of sexual abuse or harassment.

Number of standards exceeded: 1

Number of standards met: 42

Number of standards not met: 0

Number of standards not applicable: 0

<b>115.11</b>	<b>ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency has written policy D 1-8.13 mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines prevention, detection and responding to reports and mandates more specific procedures at the facility level.</p> <p>The PREA Coordinator, Vevia Sturm, and PREA Site Coordinator, Terry Page, stated they have time and authority to develop and oversee compliance and the facility has a designated PREA Compliance Manager. The PREA Coordinator reports directly to Matt Briesacher, Legal Counsel, and the PREA Site Coordinator (also the Deputy Warden) reports directly to the Warden, which supports sufficient authority.</p>	
<b>115.12</b>	<b>CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>CRCC does not contract for confinement.</p>	
<b>115.13</b>	<b>SUPERVISION AND MONITORING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 mandates that each facility maintains a staffing plan that provides for adequate staffing levels as well as an annual review of the staffing plan which includes the consultation of the PREA Coordinator. The average daily number of offenders at CRCC is 1463 and the staffing plan is predicated on a maximum base of 1470 offenders. Each required element was well documented in "The PREA Staffing and Yearly Reporting Implementation Team" report, which was provided for auditor review. Regarding deviations from the staffing plan, it states, "Deviations from those established staffing patterns is reflected within shift summary reports, custody staffing rosters, custody overtime records and shift chronological logs. This documentation may include notation within activity logs reflecting activities that were cancelled or rescheduled to a time when adequate supervision was present." CRCC stated they do not deviate from the staffing plan. This is possible because they do not have a lot of overtime and if needed they use mandatory overtime. They stated they have not used</p>	

mandatory overtime in several years.

Agency policy D1-8.13 and facility policy SOP D1-8.13 mandates unannounced rounds by supervisory staff. This is achieved through post orders for custody supervisory staff. "Additionally, chief administrative officers ensure all staff post orders include a general order prohibiting staff from alerting other staff members that supervisory rounds are occurring, unless such announcement is related to legitimate operational functions of the facility." These rounds are documented on the staff sign-in logs, which auditors reviewed throughout the facility.

<b>115.14</b>	<b>YOUTHFUL INMATES</b>
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| <input type="checkbox"/>   | Exceeds Standard (substantially exceeds requirement of standard)  |  |                                     |   |                          |   |
| <input checked="" type="checkbox"/>  | Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |  |                                     |   |                          |   |
| <input type="checkbox"/>   | Does Not Meet Standard (requires corrective action)   |  |                                     |   |                          |   |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 prohibits the placement of youthful offenders in a housing unit in which they would have sight, sound, or physical contact with any adult offender through the use of a shared dayroom or other common space, shower area, or sleeping quarters. CRCC, however, does not house youthful offenders.

In assessing the compliance at the agency level, auditors noted that State of Missouri regulation, Chapter 217 Department of Corrections Section 217.345, prohibits the placement of youthful offenders with adult offenders and requires physical separation and separate housing units. Institutional Services Procedure Manual, IS5-1.1 Diagnostic Center Reception and Orientation, outlines the procedure for notification, transportation, and housing of youthful offenders in the event one is admitted. Institutional Services Procedure Manual, IS5-3.1 Offender Housing Assignments, states, "youthful offenders will only be housed with other youthful offenders (standard operating procedures (SOP) will be developed to specify how such housing assignments will be made)."

<b>115.15</b>	<b>LIMITS TO CROSS GENDER VIEWING AND SEARCHES</b>
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| <table border="0"><tr><td><input type="checkbox"/></td><td>Exceeds Standard (substantially exceeds requirement of standard)</td></tr><tr><td><input checked="" type="checkbox"/></td><td>Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</td></tr><tr><td><input type="checkbox"/></td><td>Does Not Meet Standard (requires corrective action)</td></tr></table> | <input type="checkbox"/>  | Exceeds Standard (substantially exceeds requirement of standard) | <input checked="" type="checkbox"/> | Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) | <input type="checkbox"/> | Does Not Meet Standard (requires corrective action) |
| <input type="checkbox"/>   | Exceeds Standard (substantially exceeds requirement of standard)  |  |                                     |   |                          |   |
| <input checked="" type="checkbox"/>  | Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |  |                                     |   |                          |   |
| <input type="checkbox"/>   | Does Not Meet Standard (requires corrective action)   |  |                                     |   |                          |   |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy addresses 115.15(a), (d), (e), and (f), while (b) is N/A. Institutional Services Procedure Manual, IS20-1.3 mandates male offender pat searches are conducted by same gender staff when multiple officers are present and cross gender pat searches of female offenders only under exigent circumstances. In the event a cross gender pat search of a female offender occurs, a cross gender search form and report is submitted to the PREA Site Coordinator for review to ensure that exigent circumstances did in fact warrant the search. Cross gender strip searches are allowed only under exigent circumstances. The Procedure Manual outlines the procedures for strip searches and cross gender strip searches, which mandates the use of a cross gender strip search form and report to be submitted to the PREA Site Coordinator for review also. The PREA Site Coordinator documents their review of the cross gender searches on the Cross Gender Search Review form, which accounts for whether the



circumstances were determined to be exigent. If exigent circumstances were not present, the Cross Gender Search Review form prompts a referral for investigation and an account of corrective action taken. Zero (0) cross gender searches occurred during the reporting period.

Agency policy D1-8.13 and CRCC policy SOP D1-8.13 mandates the announcing of opposite gender staff upon entering the living unit, as "Attention a female is in the living area". These announcements are documented on the Chronological Log in the "bubble" of each unit. Auditors reviewed logs and both staff and offender interviews corroborated the opposite gender announcements.

Auditors reviewed the "Searches" training, in which cross gender pat searches are covered in the lesson plan and by video as well. The lesson plan indicates that the MDOC standard [for searching transgender offenders] is: Transgendered individuals should be frisk/pat searched according to the criteria of the location where they are housed (e.g. adhere to male procedure if located at a male facility/male housing area; adhere to the female procedure if housed at a female facility/female housing area. Newer draft curriculum further specifies that, "Policy IS20-1.3 states that when pat searching a transgender male offender, male staff will utilize the female search technique when searching the offender's upper torso. If the gender of the offender is unknown, a female staff member will be assigned to perform the pat search."

<b>115.16</b>	<b>INMATES WITH DISABILITIES AND INMATES WHO ARE LIMITED ENGLISH PROFICIENT</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

<b>Auditor comments, including corrective actions needed if does not meet standard</b>
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MDOC has established procedures, in policy D1-8.13, for disabled and limited English proficient offenders to benefit from all aspects of their PREA efforts. PREA brochures and acknowledgement forms are available in several languages, posters are available in English and Spanish, the NIC Speaking Up video is used along with its written transcript. The brochure is available in Braille for blind offenders and CRCC has an-SOP D5-5.1 Deaf and Hard of Hearing offenders --which outlines where to seek such services and is also posted throughout the facility. Auditors reviewed a statewide contract for interpretive services including sign language and many services for the deaf as well as many others for other language interpretation services.

Auditors noted Spanish and English signs posted throughout the facility. Auditors were told the facility did not have any hard of hearing offenders or limited English offenders but the auditors did view the policies and contracts that would be utilized for these offenders.

<b>115.17</b>	<b>HIRING AND PROMOTION DECISIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>MDOC policy D1-8.13 as well as facility policy SOP D1-8.13 prohibits the hiring or promoting of anyone that has engaged in sexual abuse with an offender in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual activity by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse. These policies also mandate the consideration of sexual harassment in determining whether to hire or promote.</p> <p>MDOC policy D2-2.2 Background Investigations further addresses background checks. This policy explicitly outlines all elements required for background investigations of all staff members (which is defined to include permanent, part-time, temporary, hourly, per diem employees and contractors, volunteers, and student interns). Part of this extensive background investigation is a criminal records check utilizing the Missouri Uniform Law Enforcement System (MULES) and the National Criminal Information Center (NCIC) system. It also specifies, for promotions and other appointments, noting; “a check will be conducted on the active employee through Central Office Human Resources to inquire if there has been any formal discipline for sustained allegation(s) of sexual abuse and/or harassment of an offender or resident. All sustained allegations will be considered by the department before an employee is promoted or considered for other appointments.”</p> <p>Both agency and facility policy (D1-8.13 and D2-2.2) as well as the employment application assert that material omissions are grounds for termination and address the contacting of previous institutional employers. MDOC Department Procedure Manual D2-11.14 Annual Employment Requirements asserts that criminal history checks are conducted annually, congruent to the employee’s birth month.</p> <p>Auditors ascertained, regarding the release of information about former employee misconduct, the agency is able to provide such information if the former employee was charged with offender sexual abuse (as it would be a public record). They would be prohibited from providing information on sustained administrative cases unless written consent of the former employee was obtained.</p> <p>During the reporting period, CRCC had 74 new hire employees; all of which had background checks. Auditors reviewed employee files at random; each contained records of background checks and auditors were also provided the compilation of contractor background checks to review as well. Documentation of promoted employees also contained internal inquiries regarding misconduct involving sexual abuse or sexual harassment.</p> <p>Staff interviewed were able to articulate elements and practice of agency and facility policy.</p>	
<b>115.18</b>	<b>UPGRADES TO FACILITIES AND TECHNOLOGY</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Though, there were no substantial expansions or modifications at CRCC, it was noted several	

adjustments that had been implemented in an effort to increase sexual safety and offender privacy; i.e. increased lighting, additional cameras, some of this was done after a review of an incident in the food service area.

As of early July 2014, relevant PREA standards were added to the Design Info Packet, used for modification or expansion projects. Auditors were provided email communication as evidence of this change in practice.

In addition, agency procedure D4-4.8 Security Camera Operations contains the language of 115.18(b).

<b>115.21</b>	<b>EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

CRCC conducts their own administrative investigations. MDOC Procedure D1-8.8 Evidence Collection, Accountability and Disposal extensively outlines the agency's uniform evidence protocol, which appears to be substantially congruent with "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents." Interviews of investigative staff as well as random and specialized staff indicated the application of this protocol. Knowledge of evidence collection and securing the crime scene was consistent.

All forensic exams are conducted off site by SANE's and agency policy D1-8.13, Section G. Health Services Care, delineates the protocol thereof. During the reporting period, three (3) times offenders were sent for forensic exams and all were conducted by SANE's. A victim advocate is offered at the hospital, to accompany an offender through the exam process. This protocol asserts that a CRCC QMHP (Qualified Mental Health Professional) will assess a victim within 2 hours of receiving notification (or within 2 hours of the offender returning from a SANE). It was reported that the local community-based organization has very limited resources to offer. While on-site, auditors learned that CRCC has designated the position of chaplain as a victim advocate and acquired off site advocacy training. Interview of the chaplain indicated the application of the training received and of examples of services that had been provided to offenders.

<b>115.22</b>	<b>POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

The agency does ensure that an investigation is completed for all allegations of sexual abuse or sexual harassment and is mandated by agency policy D1-8.13 and facility policy SOP D1-8.13. Administrative investigations are conducted by Administrative Inquiry Officers while criminal investigations are conducted by the office of the Inspector General. There were 85 allegations during the reporting period, which resulted in 53 administrative investigations and 28 criminal investigations. Policy requires that all sustained investigations are referred for prosecution and the PREA Coordinator has a tracking system for each referral and account of each case's status referral status.

MDOC has a PREA link on their website under “Resources.” From this link, annual aggregated sexual abuse data can be viewed as well as an overview of PREA, the agency’s zero-tolerance policy, third party reporting information, and other relevant resources such as the PREA Resource Center and Just Detention International.

**115.31 EMPLOYEE TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Required training elements of 115.31(a) were reviewed by auditors in the training curriculum that has been in use during the reporting period. During the reporting period, 74 new staff were hired; all of which received this training. MDOC policy D1-8.13 mandates initial PREA training upon hire and then refreshers every two years. In the off-year, between refreshers, policy states; “the department's training staff members shall provide current information on sexual abuse and sexual harassment policies.”

In addition, if a staff member is reassigned or is transferred from a facility that houses female offenders to a facility that houses male offenders (or vice versa), agency and facility policy D1-8.13 requires staff to receive gender specific training as part of their orientation process.

Auditors reviewed training records of new staff members as well as those that had worked at CRCC for many years. Records of initial PREA training were found in employee files. Refresher training is completed online and documentation was housed in the training building. Auditors reviewed those training records as well. Training records reviewed provided documentation staff had received and understood the training.

**115.32 VOLUNTEER AND CONTRACTOR TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy and facility SOP D1-8.13 mandates training for volunteers and contractors just as it does for all staff members. MDOC’s definition of staff member includes volunteers and contractors. Auditors reviewed the lesson plan for “Volunteers in Corrections Training” and “Offender Work Release Procedures Training” which contains information about MDOC’s zero tolerance policy as well as the definitions of sexual abuse and sexual harassment, red flags of offender-on-offender sexual abuse, and reporting requirements. Volunteers and contractors are provided a brochure which contains the same information as well.

All volunteers and contractors receive training. Auditors reviewed signed acknowledgement forms.

**115.33 INMATE EDUCATION**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>All offenders do receive PREA education upon intake. MDOC utilizes the Speaking Up video, PREA brochures, and posters visible throughout the facility. At CRCC, 570 offenders during the reporting period received PREA education and, of those, 569 offenders were also provided comprehensive education within 30 days. It was reported that the 20 offenders that did not receive the comprehensive PREA education within 30 days. Two were released out to court and the other 18 were due to staff error. This has been corrected.</p> <p>A statewide directive from the Agency Director of Adult Institutions was issued in August 2012 to all wardens regarding the requirements of offender PREA education.</p> <p>As noted in 115.16 comments, offender education is available in a variety of formats and is accessible to offenders who are limited English proficient, deaf, visually impaired, or are otherwise disabled.</p> <p>Auditors reviewed the offender PREA material and noted that pertinent information was contained therein; i.e. offenders right to be free from sexual abuse and sexual harassment, avenues of reporting, zero tolerance policy. Auditors also reviewed samples of offender acknowledgement forms, of newer offenders as well as veteran offenders. Posters were abundantly visible in all areas of the institution and offenders reported consistently throughout the interviews that they understood avenues of reporting and their right to be free from sexual abuse and sexual harassment. The auditors interpreted that offenders had confidence in the reporting system and that reports are taken seriously. Policy could be enhanced to include the requirement of the 30 day comprehensive education as well as requiring the PREA education upon transfer to another facility.</p>	
<b>115.34</b>	<b>SPECIALIZED TRAINING: INVESTIGATIONS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency and facility SOP D1-8.13 mandates specialized training for all investigators and administrative inquiry officers. Designated staff members in the inspector general's office provide the training. There are 6 modules that comprise this specialized training, for a total of 36 hours of specialized training which is very extensive, addresses the effects of agency culture on sexual abuse investigations, mock crime scene investigations, panel discussion, and incorporates many external expert resources and publications.</p> <p>MDOC has a total of 41 investigators; 2 of which are employed at CRCC. Auditors reviewed training records of the CRCC investigators and, in addition, the application of the training was evident in the interviews conducted.</p> <p>Staff interviewed were able to articulate elements of training and investigation procedures.</p>	
<b>115.35</b>	<b>SPECIALIZED TRAINING: MEDICAL AND MENTAL HEALTH CARE</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)	

- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency and facility SOP D1-8.13 mandates annual specialized training for medical and mental health staff. This specialized training is four hours in length and contains the required elements of 115.35 along with relevant scenarios and group activities.

CRCC employs 49 medical and mental health staff. All received the specialized training. Auditors reviewed training records of the CRCC medical and mental health staff members. In addition, the application and retention of the training was evident during the interviews conducted.

Forensic exams are not conducted at CRCC.

The staff member interviewed was able to articulate training elements and the dynamics of sexual abuse incidents in regards to medical protocol.

**115.41 SCREENING FOR VICTIMIZATION AND ABUSIVENESS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Offenders are assessed for risk of victimization and abusiveness. Agency policy and facility SOP D1-8.13 specifically covers 115.41(a), (b), (f), (g), and (h). 570 offenders that were admitted at CRCC during the reporting period and were assessed within 72 hours of arrival. 1 offender was reportedly not assessed within 72 hours; this was due to staff following up on information they received from the inmate. It has been completed.

MDOC utilizes a "PREA Risk Assessment" as a means of internal classification to keep separate those offenders who are at a high risk sexual victimization from those that are at a high risk of being sexually abusive. MDOC procedure IS5-2.3 Offender Internal Classification outlines the implementation of the risk assessment instrument and its use in internal classification. These procedures specify; "The department utilizes an internal classification system to assist department staff members in determining appropriate housing, programs, and work assignments of offenders to ensure offender safety, institutional security, and compliance with the Prison Rape Elimination Act (PREA) guidelines." Training, documentation, reclassification, and other aspects of implementation are detailed therein.

The instrument contains all required elements of 115.41(d) and (e) and is completed and stored electronically. Each assessment results in a computer-generated score and offender classification of Alpha, Kappa, or Sigma which is considered when housing, bed, program, education, and work assignments are made. Auditors were provided a breakdown of the CRCC offender population, by internal classification type. MDOC utilizes a coding system, assigning a letter to each of the classification types, as a measure of implementing controls on this information.

It was estimated that currently approximately 90% of the offender population had been classified as

Kappa, which designates an offender as neither vulnerable nor aggressive. Auditors were informed that an enhancement to the risk screening instrument was recently implemented and is anticipated that this enhancement is likely to result in an increase in the number of offenders designated as vulnerable and aggressive.

Interviews of specialized staff indicated that the PREA Risk Assessment information and its purpose were well known and applied throughout facility operations.

<b>115.42</b>	<b>USE OF SCREENING INFORMATION</b>
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| <input checked="" type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

The use of screening information was evident to auditors throughout review of documentation and from interviews and conversations with staff. The use of the screening information is also guided by the MDOC procedure IS18-1.1 Required Activities, which in part states; "Housing unit staff members will utilize the internal classification information to designate required activities assignments for the purpose of keeping separate and/or ensuring the appropriate monitoring of those offenders at high risk of being sexually victimized from those at high risk of being sexually abusive when working or attending programming together in accordance with institutional services procedures regarding offender internal classification." Work supervisors are provided screening information to ensure the appropriate offender supervision and specific internal classification types are designated for each housing unit.

CRCC reported having transgender offenders incarcerated at CRCC. MDOC has created a Transgender/Intersex Committee that is charged with making the housing decisions of transgender or intersex offenders which, shall not be made based solely on genitalia but must consider the offender's health and safety and the security of the facility. A template "Transgender Committee Memorandum" was created and disbursed to all facilities as a means to document the process when it occurs. MDOC procedure IS5-3.1 Offender Housing Assignments asserts that, as part of the duties of a facility's Transgender Committee, noting the committee; "will review the housing assignments every 6 (six) months" and that transgender or intersex offenders will be given the opportunity to shower separately in accordance with a facility's SOP. The audit team believed the staff at CRCC is invested in this process and it showed in the documentation and the interviews with the transgender inmates.

The auditors feel CRCC exceeds this standard due to the dedication of the staff interviewed that make up the transgender committee and through the inmate interview process.

<b>115.43</b>	<b>PROTECTIVE CUSTODY</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy and facility SOP D1-8.13 asserts; "Following an allegation of offender sexual abuse or if an

offender is assessed as being at high risk of victimization, the shift commander shall ensure the offender is housed in the least restrictive housing available to ensure safety.” An assessment for least restrictive housing is mandated within 24 hours and least restrictive housing options are listed.

The pre-audit documentation review indicated there were zero (0) offenders placed in involuntary segregated housing, for any length of time, due to being at high risk for sexual victimization. However, auditors noted while on site that while offenders did not appear to be involuntarily placed in segregated housing as a result of the risk assessment, it did appear and was reported that offenders (potential victims or otherwise) are sometimes placed in segregated housing pending investigation. There were instances noted where segregation placement was voluntary. Specifically, the MDOC PREA Event Checklist documents the “recommended housing placement” and if segregated housing is used there is a space to note the reason no alternative housing was considered.

<b>115.51</b>	<b>INMATE REPORTING</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

The agency and facility provides multiple avenues of offender reporting: verbally or in writing to staff; crime tips hotline, PREA hotline, via the grievance process, or to the Department of Public Safety. The hotline calls can be made anonymously, in which an audio message is recorded and conveyed to the investigative unit. As an avenue of reporting to a public or private entity that is not part of the agency, offenders can write to the Department of Public Safety and are provided that information and address in the offender PREA brochure.

Offenders reported they were comfortable in reporting to staff and there were no indications during interviews offenders were reporting and not being responded to. Staff reported they accept reports from offenders in writing and from third parties, and they would treat any reports in the same manner and according to the coordinated response protocol.

Offenders are not detained at CRCC for civil immigration purposes.

Staff can report privately in a number of ways, to include calling the Crime Tips hotline, Staff Tips hotline, Department of Public Safety, or to administration.

Auditors reviewed an MOU between MDOC and the Department of Public Safety in which responsibilities of each entity was outlined in the event that an allegation of sexual abuse or sexual harassment is received. The entities have established a “Sharepoint” application as a mutually accessible access point for each to share and refer allegations. This was established in July 2013.

<b>115.52</b>	<b>EXHAUSTION OF ADMINISTRATIVE REMEDIES</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |



<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>CRCC is not exempt from this standard, as they do have administrative procedures to address offender grievances. Agency policy and facility SOP D1-8.13 specify that there is no limit imposed on offender sexual abuse grievances, that they can be submitted to a staff member who is not the subject of the grievance, and that there is no informal resolution required.</p> <p>There were 4 sexual abuse grievances filed during the reporting period; they all reached a final decision within 90 days. These are logged on a spreadsheet tracking the date of receipt and completion, extension (if applicable), etc. There were no emergency sexual abuse grievances reported by CRCC.</p>	
<b>115.53</b>	<b>INMATE ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES AND LEGAL REPRESENTATION</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.53</p> <p>CRCC provides offenders with access to outside victim advocates by providing addresses and telephone numbers to; Just Detention International and the Rape, Abuse and Incest National Network (RAINN). Offenders are able to call RAINN and write JDI. The information is provided to offenders via printed materials posted throughout the facility. The information provided to offenders includes a notice that mail may be subject to examination and phone calls are subject to monitoring. The majority offenders interviewed seemed to be aware of their access to these services.</p> <p>CRCC has an established memorandum of agreement with the YWCA St. Joseph to provide community based victim advocacy services to CRCC offenders. Auditors reviewed the current MOU.</p>	
<b>115.54</b>	<b>THIRD-PARTY REPORTING</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>CRCC provides a grievance procedure "Offender Complaint to Staff Member", PREA Crisis hotline, accepts verbal/written reports from family and accepts reports from the advocacy agency.</p> <p>CRCC also has a website which publishes information on how and who to report via third-party for incidents of sexual abuse or sexual harassment. The link to the website is provided below.</p> <p><a href="http://doc.mo.gov/OD/PREA.php">http://doc.mo.gov/OD/PREA.php</a>.</p>	
<b>115.61</b>	<b>STAFF AND AGENCY REPORTING DUTIES</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p>	

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 outlines compliance with Standard 115.61.

The agency requires all staff to immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment. The policy further requires the same for any incident of retaliation involving a staff member or offender.

The policy dictates no staff shall reveal any information related to a sexual abuse report to anyone other than to the extent necessary.

The policy dictates medical and mental health shall be required to report and inform the offender of their duty to report at the initiation of services and advise the offender of limitations of confidentiality.

The policy dictates an administrative and/or criminal investigation is completed for all allegations of sexual abuse or sexual harassment.

Staff members interviewed were able to articulate their duties and responsibilities subsequent to a report of sexual abuse or harassment.

CRCC provided Missouri Revised Statutes Chapter 217, Department of Corrections Section 217.410 and Missouri Revised Statutes Chapter 630, Department of Mental Health Section 630.005 as supporting documentation for this standard.

**115.62 AGENCY PROTECTION DUTIES**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 outlines compliance with Standard 115.62.

All staff interviewed, as well as the Warden, reported they would take immediate action if they learned an offender was subject to a substantial risk of imminent sexual abuse. For this audit period CRCC reported no instances of substantial risk of imminent sexual abuse to any offender.

CRCC also maintains a directive for segregated housing for protective custody that outlines procedures for offenders identified as high risk for victimization.

**115.63 REPORTING TO OTHER CONFINEMENT FACILITIES**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

<p>Agency policy D1-8.13 outlines compliance with Standard 115.63.</p> <p>During the reporting period, CRCC reported 9 allegations of an offender being abused at another facility. CRCC also reported the number of allegations CRCC received from other facilities as 2.</p> <p>Agency policy dictates the requirement of notifications between facilities being made within 72 hour time frame.</p> <p>CRCC provided 3 examples of sexual abuse reports from other facilities. CRCC also provided 1 example of a report of sexual abuse to an outside agency.</p>	
<b>115.64</b>	<b>STAFF FIRST RESPONDER DUTIES</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D 1 8.13 dictates compliance with Standard 115.64</p> <p>CRCC has a coordinated response protocol which outlines duties of first responders which includes; separating the alleged victim, preserving and protecting the crime scene and taking measures in regards to the victim to preserve physical evidence.</p> <p>Staff members interviewed were able to articulate coordinated response measures dictated by policy and training.</p> <p>CRCC provided as supporting documentation for this standard a number of examples of sexual abuse incidents where the first responders were both security and non-security staff.</p>	
<b>115.65</b>	<b>COORDINATED RESPONSE</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The CRCC "Coordinated Response to Offender Sexual Abuse" is the facility's written institutional plan of coordinated actions in the case of offender sexual abuse. This plan accounts for coordination among staff first responders, medical and mental health staff, investigators, and facility leadership which outlines a very detailed protocol distinguishing the duties of each staff member. The "Coordinated Response to Offender Sexual Abuse" is a five-page handout that outlines immediate response for first responders, supervisors, medical, mental health, investigators, PCM, and PREA Coordinator. The PREA training lesson plan also clearly outlines response protocol.</p>	
<b>115.66</b>	<b>PRESERVATION OF ABILITY TO PROTECT INMATES FROM CONTACT WITH ABUSERS</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D2-11.6 Labor Organizations dictates compliance with Standard 115.66.</p> <p>The policy clearly outlines CRCC will not enter into any collective bargaining agreement that limits the ability to remove alleged staff sexual abusers from contact with any offender pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.</p> <p>CRCC did provide the agreement between The Department of Corrections State of Missouri and The Missouri Corrections Officers Association (MOCO). The agreement was reviewed by auditors and denotes an effective date of 10/1/2014 to 9/30/2018.</p>	
<b>115.67</b>	<b>AGENCY PROTECTION AGAINST RETALIATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 contains the elements of Standard 115.67.</p> <p>The policy states the PREA Site Coordinator is responsible for monitoring retaliation.</p> <p>The policy dictates multiple measures shall be employed as means of protection for staff and offenders who fear retaliation for reporting an incident of sexual abuse or sexual harassment.</p> <p>The policy dictates monitoring shall occur for a minimum of 90 days. The policy also dictates monitoring would continue for an additional 90 days or until the victim or the reporter are no longer in fear of retaliation or the investigational inquiry disposition was unfounded.</p> <p>The items monitored are those listed in the elements of this standard. CRCC utilizes an Assessment/Retaliation checklist to document monitoring efforts.</p> <p>The policy dictates periodic status checks are completed every 30 days.</p> <p>The policy dictates any individual who cooperates with an investigation and expresses fear of retaliation; the facility will take appropriate measures to protect the individual from retaliation.</p> <p>The policy dictates monitoring will conclude when it is determined the allegation is unfounded.</p> <p>CRCC provided examples of monitoring incidents as supporting documentation.</p>	
<b>115.68</b>	<b>POST-ALLEGATION PROTECTIVE CUSTODY</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.68.</p> <p>The policy dictates offenders at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives have been made.</p> <p>The policy dictates the facility shall review the offender's status every 30 days to determine the need for continued segregation.</p> <p>The policy does not address or provide for what privileges, access to programs and work opportunities are available to offenders placed in involuntary segregation or if it is documented what access has been limited, the duration of any limitation, or the reason(s) they are limited however; CRCC provided a "Segregated Housing for Protective Custody" form and facility administrative memo both of which direct staff to notify offenders of programing and privileges that will be restricted.</p> <p>CRCC also provided as supporting documentation for this standard 4 examples of "Hearing Classifications" proceedings where protective custody placement was considered as a response to sexual abuse incidents.</p> <p>Auditors reviewed investigation reports and documentation noting CRCC considers alternatives to involuntary segregation in accordance with standard 115.43.</p>	
<b>115.71</b>	<b>CRIMINAL AND ADMINISTRATIVE INVESTIGATIONS</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D 1-8.1 and D 1-8.4 dictate compliance with Standard 115.71.</p> <p>CRCC's investigation division is under the jurisdiction of the Inspector General's Office. CRCC investigators maintain specialized training in sexual abuse investigations. Investigators conduct administrative and criminal investigations.</p> <p>Investigators are trained to collect and preserve evidence, interviewing, report writing and continuing an investigation to prosecution when warranted. Investigation reports are well documented and are maintained by the agency. Both policy and practice supported that all sustained cases were referred for prosecution. The PREA Coordinator has a tracking system which accounts for each referral and the status thereof.</p> <p>CRCC provided investigations for pre-audit review as supporting documentation which included examples of investigation request and examples of third party reports. Auditors also reviewed investigation files on-site. Investigations reviewed indicated they were done in a prompt, thorough and objective manner.</p> <p>CRCC also provided as supporting documentation for this standard 3 examples of cases which were referred for prosecution.</p>	

The agency investigator interviewed was able to articulate elements of this standard and provided elements of agency training and investigations protocol. The investigator interviewed was also able to articulate procedures for counseling with prosecutors and outside law enforcement agencies.

**115.72 EVIDENTIARY STANDARDS FOR ADMINISTRATIVE INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility does not employ a standard higher than a preponderance of evidence as proof in determining whether allegations of sexual abuse or sexual harassment are substantiated. Review of the investigations supported this as practice.

**115.73 REPORTING TO INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility compliance with Standard 115.73.

The policy dictates, upon the conclusion of an investigation, the facility informs the offender whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

115.73(b) is not applicable to this audit.

The policy dictates that following an allegation involving staff-on-offender sexual abuse, (unless determined to be unfounded) the facility informs the offender when; the staff member is no longer posted within the offender's living unit, the staff member is no longer employed at the facility, the agency learns the staff member has been indicted on a charge related to sexual abuse, or the agency learns the staff member has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing this offender notification.

The policy dictates that, following an offender's allegation he/she has been abused by another offender, the facility informs the alleged victim when; the agency has learned the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or the agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing the notification to the offender.

The policy dictates the notifications shall be done in writing.

CRCC provided examples of notifications for auditor review.

**115.76 DISCIPLINARY SANCTIONS FOR STAFF**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 and Policy D2-11.10 dictate compliance with Standard 115.76.  The policy dictates staff are subject to disciplinary sanctions up to and including termination for violations of agency sexual abuse or sexual harassment policies.  The policy dictates termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse.  Policy D2-11.10 Staff Member Conduct addresses incidents of staff misconduct of a sexual nature and includes sexual abuse and harassment of offenders.  Policy D1-8.13 dictates terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.  Review of investigations indicated that staff are disciplined for violating the agency sexual abuse and sexual harassment policy. CRCC reported there were no incidents to report to relevant licensing bodies during this audit period.	
<b>115.77</b>	<b>CORRECTIVE ACTION FOR CONTRACTORS AND VOLUNTEERS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 dictates compliance with Standard 115.77.  The policy dictates contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement and relevant licensing bodies.  The policy further dictates the facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in cases of any other violations.  Policy D2-13.1 Volunteers addresses conduct pertinent to volunteers and dictates any allegation of sexual abuse or sexual harassment will be referred for investigation.  CRCC reported there were no incidents involving a contractor or volunteer to report to law enforcement or relevant licensing body during this audit period.	
<b>115.78</b>	<b>DISCIPLINARY SANCTIONS FOR INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 dictates compliance with Standard 115.78.</p> <p>The policy dictates offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding the offender engaged in offender-on-offender sexual abuse.</p> <p>The policy dictates sanctions shall be commensurate with the nature of and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories.</p> <p>The policy dictates an offender's mental disability or mental illness contributed to his behavior when determining sanction(s).</p> <p>The policy dictates if found guilty, the offender shall be referred for appropriate treatment to include therapy or counseling by mental health staff.</p> <p>The policy dictates an offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent.</p> <p>CRCC provided MDOC Conduct and Rules Sanctions IS19-1.1 addressing consensual and non-consensual sexual activity of offenders.</p> <p>CRCC provided a facility directive/memo which details considerations for mental disability or mental illness of offenders in conjunction with the offender disciplinary process. CRCC also provided a referral form utilized by MDOC for input/feedback from a qualified mental health practitioner in sustained cases of offender on offender sexual abuse.</p>	
<b>115.81</b>	<b>MEDICAL AND MENTAL HEALTH SCREENINGS; HISTORY OF SEXUAL ABUSE</b>
<p><input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)</p> <p><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)</p> <p><input type="checkbox"/> Does Not Meet Standard (requires corrective action)</p>	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy IS11-32 Receiving Intake Unit and D1-8.13 Offender Sexual Abuse and Harassment address compliance with Standard 115.81.</p> <p>Both policies dictate that if an offender discloses victimization or perpetration of sexual abuse whether it occurred in an institutional setting or in the community, staff offer a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The Adult Internal Risk Assessment (PREA screening) documents whether a mental health referral was accepted or declined and, if accepted, prompts staff to complete the mental health referral.</p> <p>Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments or as otherwise required by state or local law.</p>	



Both policies dictate medical and mental health practitioners shall obtain informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18.

CRCC also provided medical and mental health PREA event logs and offender confinement records as supporting documentation for this standard.

<b>115.82</b>	<b>ACCESS TO EMERGENCY MEDICAL AND MENTAL HEALTH SERVICES</b>
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|--|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.82.

The policy dictates that offenders shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The scope of such services is to be determined by medical and mental health practitioners according to professional judgment. Documentation and specialized staff interviews supported this as practice.

The policy dictates that offender victims of sexual abuse while incarcerated shall be offered timely information about and time access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate.

The policy dictates services will be provided to the victim without financial cost whether the victim names the abuser or cooperates with the investigation.

CRCC utilizes CORIZON as the medical provider and provided Part 2.4 of the contractual agreement between CRCC and CORIZON as supporting documentation denoting CORIZON's obligation to provide medical and mental health services to CRCC offenders in compliance with the PREA Standards.

The same contractual agreement denotes in the Offsite Hospital Care section, CORIZON will be responsible for and will arrange timely payment for all hospital care and related health care expenses.

Staff interviewed articulated facility practice and agency policy in regards to medical and mental health care provided in incidents of sexual abuse.

<b>115.83</b>	<b>ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS</b>
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|--|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.83.

CRCC offers medical and mental health evaluations and, as appropriate, treatment to all offenders who

have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The policy dictates follow-up services shall be provided and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or release from custody.

The policy and practice indicates that CRCC provides services consistent with the community level of care.

The policy dictates victims of sexual abuse shall be offered prophylaxis for sexually transmitted infections.

115.83(d), (e), do not apply as CRCC is an all-male facility.

The policy dictates treatment services are provided without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation.

The policy dictates an offender perpetrator of sexual abuse shall receive mental health evaluation by a qualified mental health practitioner within 60 days of learning of such abuse.

CRCC provided examples of follow up care provided to offenders as supporting documentation for this standard.

<b>115.86</b>	<b>SEXUAL ABUSE INCIDENT REVIEWS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.86.

The policy dictates CRCC shall conduct a sexual abuse incident review, or “debriefings,” at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation was determined to be unfounded. It is documented on the PREA sexual abuse debriefing form and submitted to the PREA Coordinator, Chief Administrative Officer, and assistant division director.

The policy dictates such reviews shall be held within 30 days of a formal investigation, that the review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners, and that facilities shall implement the recommendations for improvement or document its reasons for not doing so.

CRCC provided as supporting documentation a sample review which documented all elements of Standard 115.86(d) 1-6.

Auditors concluded inclusive with supporting documentation provided by CRCC, staff interviewed articulated the importance of sexual abuse reviews and their relevance to enhance the safety of offenders and staff.

<b>115.87</b>	<b>DATA COLLECTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.87.</p> <p>The policy describes the collection of uniform data by the Agency PREA Coordinator. Data is collected and reported on BJS Survey of Sexual Violence in addition to maintaining data in the information network (COIN) system. Policy and practice indicated that data is collected annually, at a minimum.</p> <p>CRCC provided documentation of monthly incident based data for years 2013 and 2014, and the annual report by facility for 2013.</p> <p>115.87(e) does not apply to this audit.</p>	
<b>115.88</b>	<b>DATA REVIEW FOR CORRECTIVE ACTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 dictates compliance with Standard 115.88.</p> <p>The policy outlines the Agency PREA Coordinator's responsibilities in collecting and aggregating data and preparing an annual report, pursuant to 115.88. Data was available and was reviewed by auditors on the agency's website.</p> <p>Data is collected and used to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. Problem areas are identified and corrective actions are noted on an ongoing basis. The agency prepares an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.</p> <p>The report(s) compares data from previous years along with corrective actions and denotes the agency's progress in addressing sexual abuse.</p> <p>The reports are submitted and approved by the agency head, the Agency PREA Coordinator, and are provided on the agency's website. The website was reviewed by auditors and was found to be compliant with element(s) of this standard.</p> <p>The agency redacts specific material from reports when publication would present a clear and specific threat to the safety and security of a facility. The agency indicates the nature of the material redacted.</p> <p>CRCC provided the CRCC PREA yearly report for 2013 and the Missouri Department of Corrections yearly PREA report for 2013 as supporting documentation.</p>	

<b>115.89</b>	<b>DATA STORAGE, PUBLICATION, AND DESTRUCTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 and practice assert that data is securely retained. Data is available via website and can be viewed by the public. Personal information is redacted.	

**AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of agency under review.

*Mark A. Mora*

1/28/2015

\_\_\_\_\_  
Auditor Signature-Mark A. Mora

\_\_\_\_\_  
Date

*Ron Baker*

1/28/2015

\_\_\_\_\_  
Auditor Signature-Ron Baker

\_\_\_\_\_  
Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

<b>Name of facility:</b>		Eastern Reception Diagnostic & Correctional Center	
<b>Physical address:</b>		2727 Highway K, Bonne Terre, MO 63628	
<b>Date report submitted:</b>		April 27, 2015	
<b>Auditor Information</b>		<b>Joseph Z. Martin</b>	
<b>Address:</b>		374 New Bethel Church Road, Fredonia, KY 42411	
<b>Email:</b>		Joseph.martin@ky.gov	
<b>Telephone number:</b>		270 388-1048	
<b>Date of facility visit:</b>		April 7th– 9th, 2015	
<b>Facility Information</b>			
<b>Facility mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b>		(573) 358-5516	
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b>		Jason Lewis	<b>Title:</b> PREA Compliance Manager
<b>Email address:</b> Jason.Lewis@doc.mo.gov		<b>Telephone number:</b>	(573) 358-5516
<b>Agency Information</b>			
<b>Name of agency:</b>		Missouri Department of Corrections	
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>		Missouri Department of Corrections	
<b>Physical address:</b>		2729 Plaza Drive P.O. Box 236 Jefferson City, MO. 65102	
<b>Mailing address:</b> <i>(if different from above)</i>		Same as above	
<b>Telephone number:</b>		(573) 751-2389	

<b>Agency Chief Executive Officer:</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director
<b>Email address:</b>		<b>Telephone number:</b>	(573) 526-6607
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b>	Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b>	Vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	(573) 522-3325

## AUDIT FINDINGS

### NARRATIVE:

The site visit for the PREA Audit of the Eastern Reception Diagnostic & Correctional Center was conducted on April 7<sup>th</sup> – 9<sup>th</sup>, 2015. The audit team consisted of the Audit Chair, Joe Martin KDOC/DOJ Certified PREA Auditor with two support staff consisting of Debra Banks KDOC/DOJ Certified PREA Auditor and Brad Adams KDOC/DOJ Certified PREA Auditor. During the Pre-Audit phase, the team reviewed the standards and completed much of the file review prior to the site visit.

An entrance meeting was held at the beginning of our on-site visit with the following staff in attendance: MDOC PREA Coordinator Vevia Sturm, Warden Troy Steele, Deputy Warden/PCM Jason Lewis, Deputy Warden Joe Hoffmeister, Major David Vandergriff and Assistant Warden Stan Jackson. Greetings and introductions were made by all and the audit team introduced themselves with a short history of their PREA Audit experience along with their correctional backgrounds. The team discussed our schedule of first wanting to tour the facility following the recommended tour guide from the PRC website and then interviewing the previously indicated staff and inmates for random and specialized interviews.

During the three day on-site portion of the audit, the team completed any necessary file review follow-up, toured the institution and conducted formal staff and inmate interviews. The team interviewed 23 inmates consisting of 11 random, 2 who reported sexual abuse, 3 disabled or limited English proficient, 4 who had disclosed sexual victimization during assessment, 2 LGBTI and 1 who was placed in segregation after allegedly suffering sexual abuse. In addition, the team interviewed 45 staff consisting of the Warden, the PREA Compliance Manager, 2 human resources, 9 random correctional officers, 4 medical or mental health, 3 intake, 3 investigators, 1 charged with monitoring retaliation, 3 that serve on the Incident Review Team, 1 who performs risk screening, 5 who have been first responders, 4 intermediate to higher level supervisors, 5 who supervise inmates in segregated housing and 3 volunteers.

### DESCRIPTION OF FACILITY CHARACTERISTICS:

ERDCC is a level 5 2,721 bed male facility located on 213 acres, approximately one mile east of Highway 67 on Highway K in Bonne Terre, Missouri, which serves as the reception facility for male offenders committed by the courts in Eastern Missouri. The perimeter of the facility encompasses 76 acres, which has 19 buildings, including four reception and diagnostic housing units, one minimum

security housing unit, six general population housing units, a building housing a gym, chapel, education, library and general population medical unit, an industries building, a building that houses reception and diagnostic intake, food service, medical, records, psychology and custody supervisory offices. In addition, the administration building houses all administrative offices, the officer's assembly room, visiting entrance, main control center entry and armory.

Outside the perimeter are two buildings that include maintenance, the power plant, warehouse, the cook-chill operation and the institutional mailroom.

Operational capacity is 2,721 beds, Of those beds, 1,714 are general population beds and 1,007 are Diagnostic beds. ERDCC presently has 608 personnel.

### SUMMARY OF AUDIT FINDINGS:

The team found that staff and inmates had good general knowledge of PREA. Staff showed they had been educated on their responsibilities that included knowing their reporting duties and the proper steps to follow in the case of an inmate reporting sexual abuse, Inmates knew their rights, how to report and services available for them if needed. The team was impressed with the positive aspect given to PREA by both staff and inmates.

All standards were found to be in compliance. Each standard below will have comments/ recommendations from the team member assigned to the standard.

Number of standards exceeded: 2

Number of standards met: 41

Number of standards not met: 0

Not Applicable: 0

#### **§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 outlines the departments process in preventing, detecting and responding to inmate sexual abuse and sexual harassment. MDOC has an agency-wide PREA Coordinator. In addition, each facility has a designated PREA Compliance Manager.

### **§115.12 - Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

MDOC obligates contracted entities to adopt and comply with the PREA Standards. Sample documentation of contracts verified.

### **§115.13 – Supervision and Monitoring**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

ERDCC has a staffing plan with all the components of standard incorporated. ERDCC reported no deviations from their staffing plan as they have mandatory posts and require staff to work overtime or days off if needed. The facility receives input annually from the the State Coordinator and the agency considers if adjustments are needed.

Policy D1 8.13 directs for supervisory unannounced rounds and prohibits staff from alerting other staff of the rounds. Interviews of supervisory staff corroborated this practice along with documentation.

### **§115.14 – Youthful Inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

ERDCC occasionally receives youthful offenders but only for a short time consisting of a few hours until they are transferred to a facility with proper housing. Youthful offenders are always under direct staff supervision the short time they are being assessed at ERDCC.



### **§115.15 – Limits to Cross-Gender Viewing and Searches**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy IS20-1.3 outlines standard. ERDCC reported no instances of cross-gender strip or visual body cavity searches. Policy D1-8.13 directs that inmates be able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing the inmate's buttocks or genitalia. ERDCC provided documentation of this practice and staff and inmate interviews corroborated.

### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1. 8.13 outlines standard. ERDCC has contacts with Interpreter Services if the need arises. The facility has PREA posters along with victim advocate information posted throughout the facility. They also have braille and Spanish versions available.

### **§115.17 – Hiring and Promotion Decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

MDOC does not hire or promote anyone who fails to meet stipulations outlined in this standard. The state application incorporates direct language from standard. Policy D2 2.2 and a Directive from agencies Human Resources directs practice of hiring and promoting with stipulations of this standard. The Employee Handbooks directs a continuing affirmative for employees to report this type of misconduct. In addition, criminal background checks are done for all staff annually. I spot checked a couple on-site to verify and H&R staff interviews corroborated.

### **§115.18 – Upgrades to Facilities and Technology**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D4. 4-8 incorporates direct language from standard. ERDCC had updated video monitoring throughout the facility.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency utilizes investigators from the Inspector Generals office which is part of the MDOC. Policy D1-8.8 describes protocol. ERDCC utilizes the local hospital in their plan if a forensic exam was to be needed for inmate sexual abuse. ERDCC reported zero instances of this occurrence within the last 12 months. ERDCC provides victim advocacy services from a local community center.

Documentation review showed use of victim advocacy throughout investigations. ERDCC posts advocacy information throughout the facility. Inmate interviews corroborated education is being continuing given.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13 and D1-8.1 directs for all allegations of sexual abuse and sexual harassment to be investigated. Documentation review proved investigations are conducted appropriately and thoroughly. Staff interviews corroborated understanding of their responsibilities for referrals for criminal behaviors.

### **§115.31 – Employee Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines employee training and PREA. Lesson Plans and curriculum used covers all aspects of section (1) –(10) used in basic training and refresher training. MDOC has different lesson plans for staff working at male or female facilities. MDOC requires acknowledgment forms from staff who complete this training and documentation is kept.

### **§115.32– Volunteer and Contractor Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 -8.13 outlines this standard. ERDCC reported 239 volunteers or contractors had received training. ERDCC maintains documentation of participation and acknowledgment forms are kept.

### **§115.33 – Inmate Education**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

ERDCC educates newly arrived inmates of the agencies zero-tolerance regarding sexual abuse and sexual harassment and to report such incidents. ERDCC shows videos to new arrivals which covers all components of this standard. ERDCC reported 5,523 inmates had been educated within the last 12 months. ERDCC provides this education to inmates who are handicapped or disabled. Documentation and acknowledgement forms are maintained of this training.

### **§115.34 – Specialized Training: Investigations**

- X Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

ERDCC exceeds this standard as their administrative and criminal investigators have received specialized training on how to conduct sexual abuse and/or sexual harassment investigations in confinement settings. The training curriculum and lesson plans used exceed the requirements outlined in this standard.

### **§115.35 – Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines requirements of this standard. ERDCC reported 100 % of it's medical/mentalhealth staff have received this training. Documentation provided and staff interviews corroborated they have.

### **§115.41 – Screening for Risk of Victimization and Abusiveness**

X Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 covers risk assessments. ERDCC exceeds the standard because the facility is meeting with all of the inmates within the 30 day time frame for re-assessment and completing a new document each time which is not required. Confidentiality does not appear to be an issue and access to these assessments are limited.

### **§115.42 – Use of Screening Information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The facility provided documentation on site to show how the information is being used as it relates to Alpha, Sigma and Kappa designated inmates.

The Audit team recommended that a facility committee be appointed to identify specific jobs or programs (if any) that would be of a concern for high-risk inmates. The warden and executive staff were very receptive of this and planned for these meetings. The Audit team also recommended better communication with job or program supervisors to ensure knowledge is possessed of high-risk inmates.

### **§115.43 – Protective Custody**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 covers Protective Custody. The documents reviewed indicate that inmates were placed in segregation based on requesting protective custody. Staff interviews indicated that if both inmates were placed in Administrative segregation based on a type of incident, they review those within 24 hours and release the “victim” if there are no other issues with the individual.

### **§115.51 – Inmate Reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Offender Guide to Sexual misconduct is provided to inmates. At every location the hotline for reporting sexual abuse is posted. Inmates are informed of ways they can report sexual abuse and the inmate interviews indicated a positive response to this standard and indicated a very positive response to reporting any incidents to staff members at the facility.

### **§115.52 – Exhaustion of Administrative Remedies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

D5-3.2 covers this standard. The grievance procedure covers all of the PREA requirements and the inmate interviews indicated a positive response to knowing this standard and use of the grievance mechanism.

### **§115.53 – Inmate Access to Outside Confidential Support Services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Posters were placed in all areas including intake which indicated several ways inmates can receive support services including Just Detention International (JDI) and Rape, Abuse and Incest National Network (RAINN). The Southeast Missouri Family Violence Council is the local victim advocacy center for ERDCC. Inmate interviews indicated an understanding of these services.

### **§115.54 – Third-Party Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Missouri DOC website has PREA information and how to report prominently displayed. This information is also posted throughout the facility.

### **§115.61 – Staff and Agency Reporting Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 covers this standard. Staff appear knowledgeable on how to report incidents of sexual abuse/harassment and know their roles. The Coordinated response protocol covers reporting to investigators.

### **§115.62 – Agency Protection Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 covers this policy. Segregated housing would be utilized if needed and staff understand their responsibility to protect inmates from imminent sexual abuse.

### **§115.63 – Reporting to Other Confinement Facilities**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 and the Coordinated Response cover this standard. Documentation was provided and showed e-mail notifications to another agency regarding an allegation of sexual abuse.

### **§115.64 – Staff First Responder Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

There were positive staff interviews from security on their role as first responders of knowing their duties and responsibilities. The Audit team recommends further education for non-security staff members to ensure requirements for all staff.

### **§115.65 – Coordinated Response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The facility was utilizing a state-wide response plan and documentation shows the plan was being followed. The facility created a facility specific plan on-site to meet this standard.

### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The new collective bargaining agreement began 10/01/2014 and all contained in the agreement meets this standard.

### **§115.67 – Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 covers this standard. Documentation was provided showing compliance with this standard. Inmate interviews were positive showing one component of a good reporting culture.

### **§115.68 – Post-Allegation Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Segregated housing is only used after alternate housing has been considered. The Shift supervisor assesses this need in consultation with other staff and documentation is completed. Inmate interviews showed positive responses to this standard as well.

### **§115.71 – Criminal and Administrative Agency Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)



ERDCC investigators are under the jurisdiction of the Inspector's General's office. All investigators are trained in compliance with standard 115.34. policy D1 8.4 addressed this standard. Reviews of the investigative files and interviews with investigators confirmed compliance. Investigators conducted thorough and complete investigations with an understanding and knowledge of their duties and a knowledge of the standard.

### **§115.72 – Evidentiary Standard for Administrative Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies D1 8.4 and D1 8.13 address this standard. Both policies dictate that the agency shall impose no standard higher than a preponderance of the evidence. Interviews and reviews of the investigative files confirmed compliance.

### **§115.73 – Reporting to Inmate**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. There is a departmental form used for notification to offenders. ERDCC provided documentation of notifications that meet the requirements of this standard. Documentation and interviews with staff and offenders confirmed compliance.

### **§115.76 – Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. ERDCC did not report any incidents of staff termination, one employee resigned prior to termination. There were no incidents reported to any relevant licensing bodies. Interviews and documentation confirmed compliance.

### **§115.77 – Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. ERDCC reported no incidents of any contractors or volunteers engaging in sexual abuse of an offender. Policy and interviews confirmed compliance and details the actions in place if an incident occurred.

### **§115.78 – Disciplinary sanctions for inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. Offenders are subject to disciplinary action following an administrative finding of guilt for offender on offender sexual abuse. The department has a form that documents input from mental health staff prior to imposing sanctions. The facility reported no incidents of disciplining an inmate for sexual contact with a staff member who did not consent. Interviews and reviews of documentation confirmed compliance.

### **§115.81 – Medical and mental health screenings; history of sexual abuse**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies ISII-32 and D1 8.13 address this standard. Documentation provided confirms that if an offender disclosed prior victimization or perpetration of sexual abuse, staff was offering a follow-up within 14 days of intake. The Risk Assessment documents when an offender accepts the follow up and prompts staff to complete a referral. Documentation and interviews confirmed compliance.

### **§115.82 – Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. Documentation provided and interviews with staff and offenders confirmed victim's access to timely, unimpeded emergency medical and mental health as well as education and services regarding sexually transmitted diseases at no cost to the offender.

### **§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. Documentation provided supports that mental health evaluations are offered to known offenders who have been victimized in any prison, jail, lock-up or juvenile facility. The services offered and provided are consistent with the community level of care. All services are provided at no cost to the inmate. The facility reported that they attempt to conduct a mental health evaluation of all known abusers within 60 days of learning of the abuse. Documentation & interviews confirmed compliance.

### **§115.86 – Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. MDOC has a departmental debriefing form that is used during the sexual abuse incident reviews. The form meets the standard and is completed within 30 days of the completion of the investigation. The appropriate and required level of staff is a part of the review and the team considers all items required by the standard. Documentation and interviews confirmed compliance.

### **§115.87 – Data Collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. All data is stored and used in compliance with the standard. MDOC submitted the SSV in 2014 to the DOJ.

### **§115.88 – Data Review for Corrective Action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. The MDOC submits an annual report and publishes this report on their website. The data is collected and used to assess the effectiveness of sexual abuse prevention. The report compares information from previous years and includes corrective actions. Reviewed the data and report that included appropriate and necessary redactions. Documentation and interviews confirmed compliance.

### **§§115.89 – Data Storage, Publication, and Destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 addresses this standard. The data is available on the website and can be viewed by anyone. The retention schedule is for 50 years. The documentation confirmed compliance.

#### **AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

Joseph Martin

Auditor Signature

4/27/2015

Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

**[Following information to be populated automatically from pre-audit questionnaire]**

<b>Name of facility:</b>	Farmington Correctional Center		
<b>Physical address:</b>	1012 West Columbia Street Farmington MO 63640		
<b>Date report submitted:</b>	February 16, 2015		
<b>Auditor Information</b>			
<b>Address:</b>	PO Box 337 Pewee Valley KY 40056		
<b>Email:</b>	shannon.butrum@ky.gov		
<b>Telephone number:</b>	502-241-8454		
<b>Date of facility visit:</b>	January 27 <sup>th</sup> through 29 <sup>th</sup> , 2015		
<b>Facility Information</b>			
<b>Facility mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b>	573-218-7100		
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b> Mike Gann			<b>Title:</b> Deputy Warden
<b>Email address:</b> mike.gann@doc.mo.gov			<b>Telephone number:</b> 573-218-1700
<b>Agency Information</b>			
<b>Name of agency:</b>	Missouri Department of Corrections		
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>			
<b>Physical address:</b>	2729 Plaza Drive Jefferson City MO 65102		
<b>Mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b>	573-751-2389		
<b>Agency Chief Executive Officer</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director

<b>Email address:</b>	george.lombardi@doc.mo.gov	<b>Telephone number:</b>	573-526-6607
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b>	Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b>	vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	573-522-1634

## **AUDIT FINDINGS**

### **NARRATIVE:**

A PREA Audit was conducted at the Farmington Correctional Center (FCC) on January 27-29, 2015. Three staff from the Kentucky Department of Corrections conducted the audit. Shannon Butrum, certified as a PREA Auditor through the Department of Justice (DOJ) served as Chairperson. Joseph Martin, also certified as a PREA Auditor through the DOJ, and Debra Banks served as Support Staff. Audit documentation was reviewed prior to the on-site audit. Auditors toured the facility on January 27<sup>th</sup> and began interviews that day. Interviews of staff and inmates continued on January 28<sup>th</sup> and 29<sup>th</sup>. Inmates from each housing unit were interviewed as well as all categories of inmates required. Additional documentation review was conducted January 29<sup>th</sup> and the exit meeting was also conducted January 29<sup>th</sup>. The facility staff were courteous and helpful throughout the audit.

### **DESCRIPTION OF FACILITY CHARACTERISTICS:**

Farmington Correctional Center is located on the former grounds of the Southeast Missouri Mental Health facility. The 326-acre campus was purchased by the state in 1899. Construction of five cottages and other support buildings was completed in 1903. At its peak, it housed over 2,000 patients. In 1983, plans were made to redirect the majority of long-term patients to private nursing home care, build an appropriate facility for the newly structured mission of the Department of Mental Health and begin construction of the correctional center.

Construction and renovation of the Correctional Center was completed in 1986, with the first offenders arriving at FCC on December 4, 1986. Existing buildings had been renovated to house services such as Medical, Education, Library, Food Service, Recreation and Religion, as well as the Administration and security functions. Nine new housing units were erected, utilizing the most modern design concepts at the time, including electronically controlled movement within each of the four 50-offender wings of the housing units. 110-acres were secured by an electronically monitored, double perimeter fence and 24-hour per day perimeter patrol.

The facility was divided into two phases, with offenders separated according to security classification. A-Phase was comprised of protective custody and administrative segregation units, along with three general population units. B-Phase contained three general population units, the Social Rehabilitation Unit for those with mild mental impairment, and the Corrections Treatment Center, housing offenders in need of psychiatric care.

As new programs were developed and additional bed space was needed, other buildings from the original conversion were remodeled and now house the Farmington Treatment Center (substance abuse treatment), and the Institutional Therapeutic Community (sex offender programming). A

building to house work release, laundry, and other outside clearance offenders was also renovated and now holds 298 offenders

Farmington began construction on building 31 in February 2013, transforming it into a housing unit for juveniles. The project took approximately 7 months to complete. The first juveniles arrived on August 15, 2013, initially there were 8 offenders.

**SUMMARY OF AUDIT FINDINGS:**

All staff interviewed were knowledgeable, particularly with their reporting requirements and the immediate action needed in order to ensure inmate safety. Inmates were familiar with PREA and knew the various report methods offered to them. PREA posters and information was readily available throughout the facility and cross-gender announcements were done on a consistent basis.

Number of standards exceeded:	2
Number of standards met:	41
Number of standards not met:	0
Not Applicable:	0

### **§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has a policy, D1-8.13 Offender Sexual Abuse and Harassment, which outlines its zero tolerance policy. An agency wide PREA Coordinator has been established and a facility PREA Compliance Manager has been identified.

### **§115.12 - Contracting with other entities for the confinement of inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has ensured that newly adapted PREA language was added into all new contracts and renewals. Multiple examples were made available for review.

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### **§115.13 – Supervision and Monitoring**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Staffing Plan was reviewed and meets all the requirements of the standard. There were no deviations from the plan but a plan is in place to document if one does occur as verified by the Wardens interview. The agency has two policies, D1-8.13 Offender Sexual Abuse and Harassment and IS 20-1.1 Post Orders that address the requirements of section (d). Supervisors conduct unannounced rounds on all shifts throughout the facility.

### **§115.14 – Youthful Inmates**

X Exceeds Standard (substantially exceeds requirement of standard)



☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has two policies, IS5-3.1 Offender Housing Assignments and D1-8.13 Offender Sexual Abuse and Harassment, which address the requirements of the standard. FCC is able to house youthful offenders in compliance with the standard without the use of isolation while still providing the offenders with all services offered to offenders housed in general population. It was observed and verified during interviews with staff that work with the youthful offender population that keeping the youthful offenders separated from adult offenders is a priority at FCC. The unit set up and services offered to the youthful offenders was impressive.

### **§115.15 – Limits to Cross-Gender Viewing and Searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has multiple policies, IS20-1.3 Searches; Di-8.13 Offender Sexual Abuse and Harassment; IS11-34.1 Health Assessment and/or Physical Examinations at Reception, which cover this standard. Documentation noted that no cross gender cavity or strip searches had been conducted. The facility does have a plan for documenting cross gender strip searches should the need arise. The facility has had not transgender or intersex inmates during the review period but the policies above cover the requirements of section (e). The lesson plan for Institutional Searches was reviewed as well as documentation of staff attendance.

Cross gender announcements are consistently made, as verified by staff and inmate interviews.

I recommend that the language from section (f) of this standard be added to the Institutional Searches lesson plan. Although I was able to locate items that covered the point of the standard I believe that using the actual language would make this clearer.

### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has a directive that covers this standard. The facility provided PREA brochures and acknowledgement forms in multiple languages as well as PREA posters in English and Spanish. There are also contracts with interpreters for sign language, written language, languages, and telephone that can be utilized as needed.

The inmates interviewed understood what PREA is, how to report, and their rights.

I recommend that staff is educated on the interpreter services that are available under the current contracts. During interviews many staff seemed to believe that inmate interpreters are utilized.

### **§115.17 – Hiring and Promotion Decisions**

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has multiple policies, D2-2.2 Background Investigations; D2-2.8 Promotional Appointment; D2-2.10 Re-employment Appointment; D2-5.1 Maintenance of Employee Record; D2-11.4 Annual Employee Requirements; D2-13.1 Volunteers; D2-13.2 Student Interns, which cover the requirements of the standard. All Human Resource staff interviewed were very knowledgeable on the requirements of this standard during their interview and provided multiple examples for reviewed during the on-site portion of the audit. Agency policy, D2-11.4, exceeds the standard by requiring annual background checks on employees during their birth month.

### **§115.18 – Upgrades to Facilities and Technology**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The facilities annual PREA Report and a list of updates that have been made were both reviewed and met the requirements of the standard.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policies, D1-8.8 Evidence Collection, Accountability, & Disposal and D1-8.13 Offender Sexual Abuse and Harassment, which cover the requirements of the standard. The protocol currently utilized by the agency was adapted by the National Evidence Collection Guidelines and from law enforcement training. The facility reported no forensic medical exams conducted during the period but has a plan with a local hospital that provides the exam at no cost to the inmate should the need arise. The agency has a Memorandum of Understanding (MOU) with the Southeast Missouri Family Violence Council to provide advocate services and also trains staff Chaplains as a another option should the community advocate be unavailable.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policies, D1-8.1 Investigation Unit Responsibilities & Actions; D1-8.4 Administrative Inquiries; D1-8.13 Offender Sexual Abuse & Harassment, which cover this standard. D1-8.13 is available on the agency website as verified prior to the audit. Examples of investigative files were reviewed on site and all met the requirements of this standard.

### **§115.31 – Employee Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has a PREA Curriculum in place that meets all the requirements of the standard. It was reviewed along with multiple examples of staff attendance.

### **§115.32– Volunteer and Contractor Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has curriculums in place, Volunteer in Corrections and Work Release Contractors, which cover the requirements of the standard. Both were reviewed along with multiple examples of volunteer and contractor attendance.

### **§115.33 – Inmate Education**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse and Harassment, which covers this standard. The facility provides brochures to inmates that are available in multiple languages and also has posters visible throughout the institution that are in English and Spanish. Comprehensive education is provided via video. Inmate records were reviewed on site showing receipt of brochure upon admittance and comprehensive education well within required 30 days.

### **§115.34 – Specialized Training: Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse and Harassment, which covers this standard. Specialized curriculum as well as documentation of staff attendance was reviewed.

### **§115.35 – Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse and Harassment, which covers this standard. Specialized curriculum as well as documentation of staff attendance was reviewed.

I recommend that wording on the sign in sheets or the acknowledgement form be added to designate as the specialized medical/mental health training.

### **§115.41 – Screening for Risk of Victimization and Abusiveness**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. The facility utilizes the Adult Internal Risk Assessment as an objective screening instrument. Interviews and documentation confirmed compliance.

### **§115.42 – Use of Screening Information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policies, D1-8.13 Offender Sexual Abuse & Harassment and IS5-3.1 Offender Housing Assignments, which cover this standard. The use of the screening instrument was confirmed through the interviews and documentation reviews.

The facility does not currently have any transgender or intersex offenders but does have a committee and policy that outlines the actions that will be taken to confirm compliance.

I recommend that a plan be developed for the restrooms located in the Education Building to ensure that offenders at high risk for victimization are able to use the restroom without being alone with offenders identified as being at high risk for abusiveness.

### **§115.43 – Protective Custody**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Facility indicates that involuntary segregation for offenders at high risk has not been utilized. The policy outlines and confirms compliance that if utilized it would meet the requirements of the standard.

### **§115.51 – Inmate Reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. The agency and facility provide multiple ways for offenders to report. Interviews with offenders confirmed compliance as well as documentation.

Staff can privately report through calling Crime Hotline and writing the Department of Public Safety as well as reporting to the Administrative Staff.

### **§115.52 – Exhaustion of Administrative Remedies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D5-3.2 Offender Grievances, which covers this standard. The facility reported no grievances have been filed regarding sexual abuse.

### **§115.53 – Inmate Access to Outside Confidential Support Services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Handbooks, orientation packets, posted posters and brochures and interviews with offenders confirmed compliance. Offenders have knowledge of the resources available and an understanding of the monitoring and the duty of staff regarding the mandatory reporting laws.

### **§115.54 – Third-Party Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency website has information regarding how to report third-party reports. Throughout the facility there is posted brochures on how to report. Interviews with Offenders confirmed knowledge of this.

### **§115.61 – Staff and Agency Reporting Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Policy requires all staff to immediately report any knowledge or information regarding an incident of sexual abuse or sexual harassment. The policy also requires staff to immediately report retaliation. Interviews confirmed staff are aware of the policy and aware of their duty to report and keep information confidential.

Policy IS11-32 Receiving Screening intake Unit covers the mandatory reporting laws.

### **§115.62 – Agency Protection Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Interviews with staff confirmed that immediate action would be taken to protect the offender. Interviews with offenders also confirmed compliance.

### **§115.63 – Reporting to Other Confinement Facilities**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. During the reporting period there were no incidents. I reviewed documentation from 2013 that confirmed compliance. The policy outlines the requirements of notification between facilities and documentation confirmed compliance with the time frame.

### **§115.64 – Staff First Responder Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Facility also utilizes a Coordinated Response Protocol that outlines first responder duties. Staff interviews confirmed compliance and awareness of their responsibilities. Documentation also revealed first responders as both security and non-security staff.

### **§115.65 – Coordinated Response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

The Coordinated Response to Offender Sexual Abuse is the institutional plan. This plan outlines the duties of first responders, medical and mental health staff, investigators and facility leadership in response to an incident of sexual abuse.

I recommend the plan be more institutional specific and include on the hospital with a SAFE or SANE nurse that will be utilized as well as information about notification and use of victim advocates at the hospital.

### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D2-11.6 Labor Organizations, which covers this standard. The facility provided an agreement between the Missouri DOC and the Missouri Corrections Officers Association, with an effective date of 10/01/2014 through 09/30/2018.

### **§115.67 – Agency protection against retaliation**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13, Offender Sexual Abuse & Harassment, which covers this standard. Documentation provided confirms monitoring for 90 days with periodic status checks every 30 days. Staff interviews confirmed monitoring would exceed 90 days if needed.

### **§115.68 – Post-Allegation Protective Custody**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, and a directive which covers this standard.

During the initial audit the facility failed this standard due to providing insufficient evidence of compliance. During the corrective action phase the facility has provided multiple examples showing evidence that they are practicing alternative means of housing therefore the team feels confident that they are in full compliance.



### **§115.71 – Criminal and Administrative Agency Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Inspector Generals Office is responsible for conducting criminal investigations. This office is part of the Missouri Department of Corrections. Administrative investigations are conducted by facility staff. Both are trained in the requirements of standard 115.34.

Agency policy D1.-8.4 Administrative Inquiries outlines this standard clearly. A review of the investigations provided showed they were thorough and complete. Interviews with the investigative staff proved good knowledge possessed of their duties and responsibilities of this standard.

### **§115.72 – Evidentiary Standard for Administrative Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.4 Administrative Inquiries clearly outlines that no standard higher than a preponderance of the evidence is used when determining the outcome of allegations of sexual abuse or sexual harassment.

Documentation review and Investigative staff interviews showed good practice and knowledge of this standard.

### **§115.73 – Reporting to Inmate**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment page 19 clearly outlines the reporting requirements of this standard. There is a departmental form used and review of documentation provided demonstrated practice. Staff and inmate interviews corroborated that notifying inmates who report sexual abuse is a common practice of the facility.

### **§115.76 – Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment page 23 outlines this standard including termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The facility reported no incidents of staff termination for violating sexual abuse or sexual harassment policies.

### **§115.77 – Corrective action for contractors and volunteers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment page 23 outlines this standard. The facility reported no incidents of where a contractor or volunteer had engaged in sexual abuse of an inmate. The Wardens interview indicated that provisions are in place that would prohibit contact if such an incident arose.

### **§115.78 – Disciplinary sanctions for inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment pages 22 and 23 outline the sections of this standard.

During the initial audit the facility failed this standard due to not providing sufficient evidence for section (c ). During the corrective action phase the facility has provided examples that input from mental health staff is received by the Adjustment officer prior to imposing a sanction for inmate on inmate sexual abuse. Therefore the team feels confident that they are in full compliance.

### **§115.81 – Medical and mental health screenings; history of sexual abuse**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy ISII-32 Receiving Screening-Intake Center page 3 outlines this standard. The facility indicated 100% of its inmates had at least been offered follow-up services for prior sexual victimization or perpetration. Medical/Mental Health staff and Risk Screening staff were very knowledgeable of this standard and the facilities practice. In addition, inmate interviews corroborated

### **§115.82 – Access to emergency medical and mental health services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Facility meets this standard as it provides timely, unimpeded emergency medical treatment to victims of sexual abuse. This includes any necessary treatment determined by medical staff's professional judgment to include education and timely access to sexually transmitted infections prophylaxis.

Medical staff interviews proved very good overall knowledge of their responsibilities for victims of inmate sexual abuse without cost to the inmate.

### **§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Facility meets this standard. The facility offers medical and mental health evaluations for all inmates who have been sexually victimized or perpetrated sexual abuse in any prison, jail, lockup or juvenile facility. MDOC medical contract with provider outlines that services provided are without cost to the inmate.

Documentation was lacking of demonstrating that mental health services were offered to inmates who had committed sexual abuse while incarcerated however staff interviews proved this practice was being done and correct documentation was provided on-site.

### **§115.86 – Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 8.13 Offender Sexual Abuse and Harassment page 18 outlines the components of this standard along with a departmental Incident Review form (Debriefing) that incorporates required parts of section (d). Facilities practice is to have medial or mental staff sit on the debriefing along with other appropriate staff. Facility provided good documentation.

### **§115.87 – Data Collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The MDOC (agency) meets the requirements of this standard as it stores all aggregated data and uses it appropriately. SSV was submitted to the DOJ for 2014. Agency policy D1 8.13 Offender Sexual Abuse and Harassment outlines.

### **§115.88 – Data Review for Corrective Action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The MDOC (agency) meets the requirements of this standard as an annual report is completed and published on its website which includes any necessary redactments. Agency policy D1 8.13 Offender Sexual Abuse and Harassment outlines. Agency/Facility staff interviews proved very good knowledge of this requirement.

Recommendation that the annual report better describe corrective actions for each facility.

### **§§115.89 – Data Storage, Publication, and Destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 8.13 Offender Sexual Abuse and Harassment pages 23 and 24 outlines this standard and the retention schedule directs storage for 50 years. Review of annual report shows no personal identifiers.

#### AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.

*Shannon R. Butrum*\_\_\_\_\_

April 27, 2015\_\_\_\_\_

Auditor Signature

Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

Name of facility: Fulton Reception and Diagnostic Center (FRDC)	
Physical Address: 1393 Hwy O, Fulton, MO 65251	
Date report submitted:	
<b>Auditor Information:</b> Elizabeth Rice, Ron Baker	
Address: Kansas Dept of Corrections, 714 SW Jackson, Suite 300, Topeka, KS 66603	
E-Mail: <a href="mailto:liz.rice@doc.ks.gov">liz.rice@doc.ks.gov</a> and <a href="mailto:ron.baker@doc.ks.gov">ron.baker@doc.ks.gov</a>	
Telephone number: 785-296-4501	
Date of facility visit: April 14-16, 2015	
<b>Facility Information</b>	
Facility mailing address: 1393 Hwy O in Fulton, MO	
Telephone number:	
The facility is:	
<input type="checkbox"/> Military	<input type="checkbox"/> County
<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal
<input type="checkbox"/> Private not for profit	<input type="checkbox"/> Federal
	<input checked="" type="checkbox"/> State
Facility Type: Adult Prison	
Name of PREA Compliance Manager: Dan Redington	Title: Deputy Warden
E-Mail Address: <a href="mailto:Dan.redington@doc.mo.gov">Dan.redington@doc.mo.gov</a>	Phone Number: 573-592-4040
<b>Agency Information</b>	
Name of agency: Missouri Department of Corrections	
Governing authority or parent agency: (if applicable) State of Missouri	
Physical address: 2728 Plaza Drive Jefferson City, MO 65109	
Mailing address: (if different from above)	
Telephone Number: 573-526-9003	
<b>Agency Chief Executive Officer</b>	
Name: George Lombardi	Title: Director
E-Mail Address: <a href="mailto:George.Lombardi@doc.mo.gov">George.Lombardi@doc.mo.gov</a>	Telephone Number: (573) 526-6607
<b>Agency-wide PREA Coordinator</b>	
Name: Vevia Sturm	Title: PREA Coordinator
E-Mail Address: <a href="mailto:Vevia.Sturm@doc.mo.gov">Vevia.Sturm@doc.mo.gov</a>	Telephone Number: (573) 522-1634

# AUDIT FINDINGS

## NARRATIVE:

In order to determine compliance with Prison Rape Elimination Act (PREA) standards an onsite audit was conducted of the Fulton Reception and Diagnostic Center (FRDC) on April 14-16, 2015 by DOJ certified auditors Liz Rice and Ron Baker and one assistant, C. J. Perez. Perez received training prior to the audit and supervision during the process from Baker and Rice.

Prior to the onsite portion of the audit, auditors provided the facility with the Auditor Notice which was posted at least 6 weeks prior to the onsite audit. The Pre-Audit Questionnaire along with other supporting documentation was provided to the auditors to review in advance of the onsite portion of the audit. Auditors appreciated the very well organized questionnaire with supporting documentation that was received and reviewed prior to the onsite visit. The same auditors conducted an onsite visit to another MDOC facility the same week and appreciate the FRDC willingness to be flexible with the schedule to accommodate both visits.

The auditors reported to FRDC on 04/14/2015 at 13:00 hrs to complete a tour of the facility. The tour was led by Deputy Warden Redington and state PREA Coordinator Vevia Sturm. The tour included all areas outside of housing units where inmates may be present and representative housing units of each type for this facility; dormitory, restrictive housing, and general population cell house. During the tour Mr. Redington provided an overview of the mission of the facility and an explanation of how offenders move through the facility from admission to transfer out or placement into permanent party housing on site. Auditors were able to observe staff and offender interaction during the tour and noticed the positive culture among staff. Offender reaction indicated that that this positive staff interaction is common place in this facility.

Following the tour the audit team discussed the audit schedule with Mr. Redington and Mrs. Sturm to ensure that the schedule would not conflict with the operational needs of the facility and provide ample opportunity for auditors to complete their required tasks. Offender and staff rosters were provided for the audit team to select people for random and targeted interviews. The audit team departed the facility and met at an offsite location to discuss the tour and to review the provided documentation with the new information gained from the tour. The Warden, Billy D. Harris, had to be away from the facility on state business until late morning on 4/15/2015, the introductory meeting was held at a time that he could be present. Also present at that meeting were the Deputy Warden of Offender Management, Michael B. Payne; Deputy Warden of Operations, Daniel W. Redington; Assistant Warden, Shawn C. Twyman; and state PREA Coordinator, Vevia Sturm.

Specialized and Random Staff interviews were conducted on 4/15/2015 and 4/16/2015 and included the Facility PCM, Warden, Shift Supervisor, Functional Unit Manager, Education, Human Resources, Contract Medical and Mental Health, Volunteers, Investigations, Intake, Segregated Housing, Incident Review, Retaliation Review, First Responders, Food Service, Maintenance, Laundry, Canteen and Counselors. Custody Staff from three shifts were interviewed. All staff was knowledgeable of FRDC and agency policy in regards to their responsibility subsequent to a report of sexual abuse or harassment and seemed very comfortable answering questions from the auditors. Interviews were held at various locations throughout the facility that provided adequate privacy and comfort for both auditor and interviewee. Investigative and Human Resource file information was made available to auditors for review. SAFE/SANE exams are conducted off site by the University of Missouri Hospital. Staff from that

facility were not interviewed.

Offender interviews were conducted on 4/16/2015 and included at least one offender from each housing unit, a hearing impaired offender, an offender who had reported sexual abuse, an offender who self-identified as bi-sexual, an inmate identified as vulnerable during risk screening, an inmate in segregated housing and offenders supervised by non-custodial staff.

Auditors were given complete access to all areas of the facility.

Each day at the facility concluded with a short out briefing to the PCM that gave auditors time to ask questions, gather additional documentation if needed, and let the PCM know of any concerns. The auditors then met off site to compare notes and to assess compliance with standards.

At the conclusion of offender interviews the auditors prepared for a final exit interview/briefing with senior staff. Those in attendance for exit briefing were Warden, Deputy Wardens, Asst. Warden, Chief of Custody, and State PREA Coordinator.

Auditors were impressed by the level of staff competencies in PREA and the overall good morale of staff and offenders in this facility. The demonstrated level of knowledge about PREA by staff is very encouraging as some agencies struggle with a culture change in trying to incorporate PREA into everyday operations. As a reception center for the state they are laying the ground work in offender education with regard to PREA that will serve the agency well as these offenders are assigned to housing throughout the state. The audit team appreciates the very well organized files and daily support provided by Deputy Warden Redington during this audit.

Members of this audit team have participated in three other audits of Missouri DOC facilities. During those audits interviews were conducted with State PREA Coordinator and Agency Head/Designee, therefore new interviews were not conducted during this onsite visit as previous interviews have been satisfactory.

#### **DESCRIPTION OF FACILITY CHARACTERISTICS**

The Fulton Reception and Diagnostic Center (FRDC) is located at 1393 Hwy O in Fulton, MO. FRDC opened in 1987 and experienced 12 years of growth to its current capacity of 1,302 adult males. No females and no youthful offenders are housed at FRDC. This facility is one of 3 reception and diagnostic centers for adult males in Missouri. There are 22 buildings that include 10 housing units on 123 acres. There are 2 open bay dormitories for housing permanent party workers with the rest of the units in use to support the intake and diagnostic functions. The facility was designed and built to function as a prison housing the reception and diagnostic functions.

Number of standards exceeded: 0

Number of standards met: 43

Number of standards not met: 0

Number of standards not applicable: 0



<b>115.11</b>	<b>ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>The agency has written policy D 1-8.13 mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines prevention, detection and responding to reports and mandates more specific procedures at the facility level.</p> <p>The PREA Coordinator, Vevia Sturm, and PREA Compliance Manager, Dan Redington, stated they have sufficient time and authority to develop and oversee compliance and each facility has a designated PREA Compliance Manager. The PREA Coordinator reports directly to agency Legal Counsel, and the PREA Compliance Manager, who is also the Deputy Warden of Operations, of whom reports directly to the Warden. Mr. Redington is highly regarded by staff at this facility and they report getting routine reminders from him about issues regarding PREA compliance. Mr. Redington indicates that he has great support from his Warden and the State PREA Coordinator.</p>	
<b>115.12</b>	<b>CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>This facility does not contract with other entities for the confinement of offenders.</p> <p>The MDOC, as parent agency, contracts with 4 community confinement facilities, although none of them are specifically tied to this facility.</p> <p>The agency contract administrator draws up the contracts, while the probation/parole division monitors compliance. Current contracts require the facilities to complete and be PREA compliant to include a PREA audit this year. Additionally, probation and parole staff conducts compliance audits every 6 months.</p>	
<b>115.13</b>	<b>SUPERVISION AND MONITORING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 mandates that each facility maintains a staffing plan that provides for adequate staffing levels as well as an annual review of the staffing plan which includes the consultation of the PREA Coordinator. The average daily number of offenders at FRDC is 1400 and the staffing plan is predicated on a maximum base of 1400 offenders. Each required element was documented in "The PREA Staffing and Yearly Reporting Implementation Team" report, which was provided in the PAQ documentation for review. Regarding deviations from the staffing plan, it states, "Deviations from those established staffing patterns is reflected within shift summary reports, custody staffing rosters, custody overtime records and shift chronological logs. This documentation may include notation within activity</p>	

logs reflecting activities that were cancelled or rescheduled to a time when adequate supervision was present." FRDC advised that they do not deviate from the staffing plan.

Agency policy D1-8.13 and facility policy mandates unannounced rounds by supervisory staff. This is achieved in part, through post orders (IS20 -1.1) for custody supervisory staff. Policy dictates that chief administrative officers ensure all staff post orders "include a general order prohibiting staff from alerting other staff members that supervisory rounds are occurring, unless such announcement is related to legitimate operational functions of the facility." These rounds are documented on the post sign-in forms which were made available for the auditors review. In addition, examples of the "Shift Monthly Area Check Board" forms were included in documentation for auditor review which satisfies the requirement the documentation piece of recording of unannounced supervisory rounds.

FRDC provided meeting minutes from its annual "Security Camera and Staffing Plan PREA Review Meeting" held in December of 2014. Agenda items included the requirements of standard 115.13 (section C specifically) which outlines that in consultation with the PREA coordinator required by 115.11, the agency shall assess, determine, and document whether adjustments are needed to:

1. The staffing plan established pursuant to paragraph (a) of this section;
2. The facility's deployment of video monitoring systems and other monitoring technologies; and
3. The resources the facility has available to commit to ensure adherence to the staffing plan.

#### **115.14 YOUTHFUL INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 prohibits the placement of youthful offenders in a housing unit in which they would have sight, sound, or physical contact with any adult offender through the use of a shared dayroom or other common space, shower area, or sleeping quarters. FRDC however, does not house youthful offenders. Upon review of available policy and documentation and in speaking with FRDC reception staff, it was derived that if a youthful offender arrives in intake, they are directly supervised by custody staff through the entirety of the intake process and are normally routed to Farmington Correctional Center the same day.

In assessing the compliance at the agency level, auditors noted that State of Missouri regulation, Chapter 217 Department of Corrections Section 217.345, prohibits the placement of youthful offenders with adult offenders and requires physical separation and separate housing units. Institutional Services Procedure Manual, IS5-1.1 Diagnostic Center Reception and Orientation, outlines the procedure for notification, transportation, and housing of youthful offenders in the event one is admitted. Institutional Services Procedure Manual, IS5-3.1 Offender Housing Assignments, states, "youthful offenders will only be housed with other youthful offenders (standard operating procedures (SOP) will be developed to specify how such housing assignments will be made)."

#### **115.15 LIMITS TO CROSS GENDER VIEWING AND SEARCHES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy IS20-1.3 addresses sections (a), (d), (e) and (f) in regard to offender searches. Section (b) is N/A due to the fact that FRDC does not house female offenders. Documentation provided under (a) advised that "FRDC has had no exigent circumstances that would require a female staff member to assist with a strip search of a male offender." Also, "MDOC staff does not conduct body cavity searches."

Agency policy D1-8.13 and FRDC policy SOP D1-8.13 mandates the announcing of opposite gender staff. These announcements are made once per shift and are documented in the chrono log of the "bubble" of each unit. Both agency and facility policy dictate that offenders will be provided privacy from being viewed by non-medical opposite gender staff when "showering, performing bodily functions and dressing" with the exception of exigent circumstances or "incidental to routine cell checks." A DAI directive addressed to all "Wardens" was reviewed by the audit team which discussed the installation of privacy screens/barriers. DAI Director Dormire set an implementation date of 8-18-13. The audit team observed said barriers during the tour. During the inmate interviews, all that were asked stated that they feel they have a reasonable expectation of privacy and alluded to confirmation of compliance of provision 115.15 (d).

A memo included in facility documentation advised that "FRDC has not received a transgender offender since August of 2012." Supporting documentation provided under 115.15(e) included an excerpt from policy D1-8.13 and IS11-34.1 "Health Assessment and Physical Examination at Reception". Also in documentation was an e-mail from PCM/Deputy Warden of Operations Dan Redington outlining procedures in the event that an offender was received whose gender was unknown; detailing the provisions of 115.15 (e).

FRDC has developed a transgender committee which consists of the Site PREA Coordinator, Health Services Administrator, Medical Director, Chief of Mental Health Services and the offender. A Transgender Committee memo template was viewed in documentation and addressed the areas of housing needs (to include showering), where the offender is in the transition process, offender views/concerns and allowed for suggestion of any other accommodations and/or recommendations.

Training curriculum on "Searches" is in place at FRDC and a corresponding lesson plan was reviewed by the audit team. The MDOC standard for searching transgender and intersex offenders is defined as search practices for cross-gender pat downs. Policy IS20-1.3 states that "when pat searching a transgender male offender, male staff will utilize the female search technique when searching the offender's upper torso. If the gender of the offender is unknown, a female staff member will be assigned to perform the pat search."

**115.16 INMATES WITH DISABILITIES AND INMATES WHO ARE LIMITED ENGLISH PROFICIENT**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

MDOC has established procedures, in policy D1-8.13, for disabled and limited English proficient offenders to benefit from all aspects of their PREA efforts. PREA brochures and acknowledgement forms are available in several languages and posters are available in English and Spanish. There is also a brochure available in Braille for blind offenders. As part of the orientation process, the NIC "Speaking Up" video is used along with its written transcript. FRDC SOP D5-5.1 "Deaf and Hard of Hearing Offenders" details where and how to seek such services and is also posted throughout the facility.

Auditors reviewed a statewide contract for interpretive services including sign language and many services for the deaf as well as many others for other language interpretation services. As of April of 2013, the contractor used for language interpretations services is AVAZA. Their services are available 24 hours/day and facility policy dictates that supervisory custody staff logs the phone call (to include start and end time of the call) and also e-mail the business of such event. During review of documentation material, auditors also viewed an example of a rate sheet and translation order form via AVAZA services.

Auditors noted Spanish and English signs posted throughout the facility. Auditors interviewed one offender that was identified as hard of hearing who had been housed at FRDC for approximately two weeks. The offender advised that he was provided with written PREA education material upon intake and was confident in his understanding of how to report an incident of sexual abuse if necessary. He informed that he is living in HU 4a which is equipped with a TTY telephone. Auditors did view the policies and contracts that would be utilized for these offenders.

FRDC intake staff maintain a monthly "Inmates with Disabilities or are Limited English Proficient" log that details the inmate name and number, date of arrival, disability/language, PREA Brochure (Y/N) and if an interpreter was used (Y/N). This information is reviewed by the Deputy Warden of Operations, Dan Redington and is used when assessing needed services and in collection of audit documentation.

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

#### **115.17 | HIRING AND PROMOTION DECISIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

MDOC policy D1-8.13 as well as facility policy SOP D1-8.13 prohibits the hiring or promoting of anyone that has engaged in sexual abuse with an offender in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual activity by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse. These policies also mandate the consideration of sexual harassment in determining whether to hire or promote.

MDOC policy D2-2.2 (Background Investigations) outlines all elements required for background investigations of all staff members. An extensive background investigation including a criminal records check utilizing the Missouri Uniform Law Enforcement System (MULES) and the National Criminal Information Center (NCIC) system is enforced. Policy also specifies, for promotions and other appointments, noting; "a check will be conducted on the active employee through Central Office Human Resources to inquire if there has been any formal discipline for sustained allegation(s) of sexual abuse and/or harassment of an offender or resident. All sustained allegations will be considered by the department before an employee is promoted or considered for other appointments."

Agency and facility policy (D1-8.13 and D2-2.2) as well as the employment application advise that material omissions are grounds for termination and address the contacting of previous institutional employers. MDOC Department Procedure Manual D2-11.14 Annual Employment Requirements asserts that criminal history checks are conducted annually, in the month following each staff member's birth month.

FRDC is able to provide information on official charges of sexual abuse or sexual harassment involving a former employee (as it would be a public record). However, they would be prohibited from providing information on sustained administrative cases unless written consent of the former employee was obtained (per MDOC policy D2-5.1-Maintenance of Employee Records).

During the reporting period, FRDC had 80 new hire employees; all of which had background checks. Employee files were reviewed at random; each contained records of background checks and auditors were also provided the compilation of contractor background checks to review as well. Documentation of promoted employees also contained internal inquiries regarding misconduct involving sexual abuse or sexual harassment.

#### **115.18 UPGRADES TO FACILITIES AND TECHNOLOGY**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

Agency procedure D4-4.8 –Security Camera Operations adheres to the elements of PREA standard 115.18 (b).

FRDC reported that there were no substantial expansions or modifications during the reporting period. It was noted that there had been several cameras (23 noted during interview with FRDC Warden Bill Harris) added in an effort to increase sexual safety within the institution.

#### **115.21 EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

MDOC Procedure D1-8.8 Evidence Collection, Accountability and Disposal provides a detailed outline of the agency's uniform evidence protocol which appears to be in line with "A National Protocol for Sexual Assault Medical Forensic Examinations, Adult/Adolescents." Interviews of investigative staff as well as random and specialized staff indicated the application of this protocol. Knowledge of evidence collection and securing the crime scene was consistent throughout staff interviews.

All forensic exams are conducted off site by SANE's and agency policy D1-8.13, Section G. Health Services Care, delineates the protocol thereof. FRDC noted that they have "had no out counts for forensic exams in the last 12 months." A victim advocate is offered at the hospital (in Columbia, Mo), to accompany the offender through the exam process. This is offered in part, as a result of the development of a Weekly Rotation schedule shared between 5 different chaplains who serve as victim advocates. Off-site advocacy training was provided and documentation indicates that all chaplains currently being utilized have received the necessary training.

**115.22 | POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

FRDC and the MDOC has policy and protocol in place to ensure that an investigation is completed for all allegations of sexual abuse or sexual harassment which is mandated by agency policy D1-8.13 and facility policy SOP D1-8.13. There were 20 allegations during the reporting period, which resulted in 11 administrative investigations and 9 criminal investigations. Policy requires that all sustained investigations are referred for prosecution and the PREA Coordinator has a tracking system for each referral and account of each case's status referral status.

MDOC has a PREA link on their website under "Resources." From this link, annual aggregated sexual abuse data can be viewed as well as an overview of PREA, the agency's zero-tolerance policy, third party reporting information, and other relevant resources such as the PREA Resource Center and Just Detention International.

**115.31 | EMPLOYEE TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Required training elements of 115.31(a) were reviewed by auditors in the training curriculum that has been in use during the reporting period. During the reporting period, 80 new staff were hired; all of which received the training. MDOC policy D1-8.13 mandates initial PREA training upon hire and then

refreshers every two years. In the off-year, between refreshers, policy states; "the department's training staff members shall provide current information on sexual abuse and sexual harassment policies."

In addition, if a staff member is reassigned or is transferred from a facility that houses female offenders to a facility that houses male offenders (or vice versa), agency and facility policy D1-8.13 requires staff to receive gender specific training as part of their orientation process.

Training records of new staff members as well as long time staff were provided for review. Records of initial PREA training were found in employee files as well as documentation of refresher training completed online. Training records reviewed and signed acknowledgement sheets provided documentation that staff had received and understood the training.

**115.32 VOLUNTEER AND CONTRACTOR TRAINING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy and facility SOP D1-8.13 mandates training for volunteers and contractors congruent with that of training for all staff members. MDOC's definition of staff member includes volunteers and contractors. Auditors reviewed the lesson plan for "Volunteers in Corrections Training" and "Offender Work Release Procedures Training" which contains information about MDOC's zero tolerance policy as well as the definitions of sexual abuse and sexual harassment, red flags of offender-on-offender sexual abuse, and reporting requirements. Volunteers and contractors are provided a brochure which reiterates the information provided in training.

All volunteers and contractors interviewed reported that they had received PREA training. Signed acknowledgement forms were provided in the audit documentation.

**115.33 INMATE EDUCATION**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

All offenders are offered PREA education upon intake to FRDC. MDOC utilizes the Speaking Up video, PREA brochures, and posters visible throughout the facility. PREA information is also run on a continuous loop on the offender information T.V. channel that can be viewed both in the intake area and respective housing units. During the 12-month reporting period, FRDC provided PREA orientation to 7459 offenders upon intake to the facility. Additionally, of the 7459 aforementioned, 6310 offenders were also provided comprehensive education within 30 days. The difference between the two was explained by noting the fact that "FRDC is a reception center therefore: offenders are only here for a short period of time. The exception would be for the perm unit consisting of 200 offenders. Their average stay is 1-2 years."

A statewide directive from the Agency Director of Adult Institutions was issued in August 2012 to all wardens regarding the requirements of offender PREA education.

As noted in 115.16 comments, offender education is available in a variety of formats and is accessible to offenders who are limited English proficient, deaf, visually impaired, or are otherwise disabled.

Auditors reviewed the offender PREA material and noted that pertinent information was contained therein; i.e. offenders right to be free from sexual abuse and sexual harassment, avenues of reporting, zero tolerance policy. Auditors also reviewed samples of offender acknowledgement forms. Posters were abundantly visible in all areas of the institution and offenders reported consistently throughout the interviews that they understood avenues of reporting and their right to be free from sexual abuse and sexual harassment. The auditors gathered that overall, offenders had confidence in the reporting system and felt that reports were taken seriously. Policy could be enhanced to include the requirement of the 30 day comprehensive education as well as requiring the PREA education upon transfer to another facility.

**115.34 SPECIALIZED TRAINING: INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy D1-8.13 mandates annual specialized training for investigative staff. "All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training by the designated inspector general's office staff members". The 6 module, 36 hour training course was reviewed by auditors along with a log of staff completing the training that indicates the 2 investigators(Dye and Snellen) assigned to FRDC have completed the required training.

**115.35 SPECIALIZED TRAINING: MEDICAL AND MENTAL HEALTH CARE**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Policy D1-8.13 mandates annual specialized training for medical and mental health staff. This specialized training is four hours in length and contains the required elements of 115.35 along with relevant scenarios and group activities.

FRDC employs 62 contract medical staff and mental health staff. A sample of training records was reviewed and indicated that all received the specialized training. During interviews of staff in this category it was clear that staff has received required training and have retained the information from the training. They were able to describe their responsibilities as first responders and as medical/mental health professionals.

Forensic exams are not conducted at FRDC.

**115.41 SCREENING FOR VICTIMIZATION AND ABUSIVENESS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)



<input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.42</b>	<b>USE OF SCREENING INFORMATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.43</b>	<b>PROTECTIVE CUSTODY</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.51</b>	<b>INMATE REPORTING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.52</b>	<b>EXHAUSTION OF ADMINISTRATIVE REMEDIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.53</b>	<b>INMATE ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES AND LEGAL REPRESENTATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.54</b>	<b>THIRD-PARTY REPORTING</b>

<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	
<b>115.61</b>	<b>STAFF AND AGENCY REPORTING DUTIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	
<b>115.62</b>	<b>AGENCY PROTECTION DUTIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	
<b>115.63</b>	<b>REPORTING TO OTHER CONFINEMENT FACILITIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	
<b>115.64</b>	<b>STAFF FIRST RESPONDER DUTIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	
<b>115.65</b>	<b>COORDINATED RESPONSE</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
Auditor comments, including corrective actions needed if does not meet standard	

<b>115.66</b>	<b>PRESERVATION OF ABILITY TO PROTECT INMATES FROM CONTACT WITH ABUSERS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<b>115.67</b>	<b>AGENCY PROTECTION AGAINST RETALIATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 contains the elements of Standard 115.67.</p> <p>The policy states the PREA Site Coordinator is responsible for monitoring retaliation.</p> <p>The policy dictates multiple measures shall be employed as means of protection for staff and offenders who fear retaliation for reporting an incident of sexual abuse or sexual harassment.</p> <p>The policy dictates monitoring shall occur for a minimum of 90 days. The policy also dictates monitoring would continue for an additional 90 days or until the victim or the reporter are no longer in fear of retaliation or the investigational inquiry disposition was unfounded.</p> <p>The items monitored are those listed in the elements of this standard. FRDC utilizes an Assessment/Retaliation checklist to document monitoring efforts.</p> <p>The policy dictates periodic status checks are completed every 30 days.</p> <p>The policy dictates any individual who cooperates with an investigation and expresses fear of retaliation; the facility will take appropriate measures to protect the individual from retaliation.</p> <p>The policy dictates monitoring will conclude when it is determined the allegation is unfounded.</p> <p>FRDC provided examples of monitoring incidents as supporting documentation.</p>	
<b>115.68</b>	<b>POST-ALLEGATION PROTECTIVE CUSTODY</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 addresses compliance with Standard 115.68.</p>	

The policy dictates offenders at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives have been made.

The policy dictates the facility shall review the offender's status every 30 days to determine the need for continued segregation.

The policy does not address or provide for what privileges, access to programs and work opportunities are available to offenders placed in involuntary segregation or if it is documented what access has been limited, the duration of any limitation, or the reason(s) they are limited. When questioned the FUM (Functional Unit Manager) stated that the facility only houses inmates short term as it is a transitional unit so inmates are not in the segregation unit for long periods of time

Auditors reviewed investigation reports, documentation and also spoke with shift supervisors and both show that FRDC considers alternatives to involuntary segregation in accordance with standard 115.43.

<b>115.71</b>	<b>CRIMINAL AND ADMINISTRATIVE INVESTIGATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D 1-8.1 and D 1-8.4 dictate compliance with Standard 115.71.

FRDC's investigation division is under the jurisdiction of the Inspector General's Office. FRDC investigators maintain specialized training in sexual abuse investigations. Investigators conduct administrative and criminal investigations.

Investigators are trained to collect and preserve evidence, interviewing, report writing and continuing an investigation to prosecution when warranted. Investigation reports are well documented and are maintained by the agency. Both policy and practice supported that all sustained cases were referred for prosecution. The PREA Coordinator has a tracking system which accounts for each referral and the status thereof.

CRCC provided investigations for pre-audit review as supporting documentation which included examples of investigation request and examples of third party reports. Auditors also reviewed investigation files on-site. Investigations reviewed indicated they were done in a prompt, thorough and objective manner.

The agency investigator interviewed was able to articulate elements of this standard and provided elements of agency training and investigations protocol. The investigator interviewed was also able to articulate procedures for counseling with prosecutors and outside law enforcement agencies.

<b>115.72</b>	<b>EVIDENTIARY STANDARDS FOR ADMINISTRATIVE INVESTIGATIONS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the |

relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 dictates facility does not employ a standard higher than a preponderance of evidence as proof in determining whether allegations of sexual abuse or sexual harassment are substantiated. Review of the investigations supported this as practice.	
<b>115.73</b>	<b>REPORTING TO INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 dictates facility compliance with Standard 115.73.  The policy dictates, upon the conclusion of an investigation, the facility informs the offender whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.  115.73(b) is not applicable to this audit.  The policy dictates that following an allegation involving staff-on-offender sexual abuse, (unless determined to be unfounded) the facility informs the offender when; the staff member is no longer posted within the offender's living unit, the staff member is no longer employed at the facility, the agency learns the staff member has been indicted on a charge related to sexual abuse, or the agency learns the staff member has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing this offender notification.  The policy dictates that, following an offender's allegation he/she has been abused by another offender, the facility informs the alleged victim when; the agency has learned the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or the agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing the notification to the offender.  The policy dictates the notifications shall be done in writing.  FRDC provided examples of notifications for auditor review.	
<b>115.76</b>	<b>DISCIPLINARY SANCTIONS FOR STAFF</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
Agency policy D1-8.13 and Policy D2-11.10 dictate compliance with Standard 115.76.  The policy dictates staff is subject to disciplinary sanctions up to and including termination for violations	

of agency sexual abuse or sexual harassment policies.

The policy dictates termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Policy D2-11.10 Staff Member Conduct addresses incidents of staff misconduct of a sexual nature and includes sexual abuse and harassment of offenders.

Policy D1-8.13 dictates terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Review of investigations indicated that staff is disciplined for violating the agency sexual abuse and sexual harassment policy. FRDC reported there were no incidents to report to relevant licensing bodies during this audit period.

**115.77 | CORRECTIVE ACTION FOR CONTRACTORS AND VOLUNTEERS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.77.

The policy dictates contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement and relevant licensing bodies.

The policy further dictates the facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in cases of any other violations.

Policy D2-13.1 Volunteers addresses conduct pertinent to volunteers and dictates any allegation of sexual abuse or sexual harassment will be referred for investigation.

FRDC reported there were no incidents involving a contractor or volunteer to report to law enforcement or relevant licensing body during this audit period.

**115.78 | DISCIPLINARY SANCTIONS FOR INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.78.

The policy dictates offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding the offender engaged in offender-on-offender sexual abuse.

The policy dictates sanctions shall be commensurate with the nature of and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories.

The policy dictates an offender's mental disability or mental illness contributed to his behavior when determining sanction(s).

The policy dictates if found guilty, the offender shall be referred for appropriate treatment to include therapy or counseling by mental health staff.

The policy dictates an offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent.

FRDC provided MDOC Conduct and Rules Sanctions IS19-1.1 addressing consensual and non-consensual sexual activity of offenders.

FRDC provided a facility directive/memo which details considerations for mental disability or mental illness of offenders in conjunction with the offender disciplinary process. FRDC also provided a referral form utilized by MDOC for input/feedback from a qualified mental health practitioner in sustained cases of offender on offender sexual abuse.

<b>115.81</b>	<b>MEDICAL AND MENTAL HEALTH SCREENINGS; HISTORY OF SEXUAL ABUSE</b>
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- |   |
|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

<b>Auditor comments, including corrective actions needed if does not meet standard</b>
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Agency policy IS11-32 Receiving Intake Unit and D1-8.13 Offender Sexual Abuse and Harassment address compliance with Standard 115.81.
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Both policies dictate that if an offender discloses victimization or perpetration of sexual abuse whether it occurred in an institutional setting or in the community, staff offer a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The Adult Internal Risk Assessment (PREA screening) documents whether a mental health referral was accepted or declined and, if accepted, prompts staff to complete the mental health referral.

Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments or as otherwise required by state or local law.

Both policies dictate medical and mental health practitioners shall obtain informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18.

FRDC also provided medical and mental health PREA event logs and offender confinement records as supporting documentation for this standard.

<b>115.82</b>	<b>ACCESS TO EMERGENCY MEDICAL AND MENTAL HEALTH SERVICES</b>
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- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.82.

The policy dictates that offenders shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The scope of such services is to be determined by medical and mental health practitioners according to professional judgment. Documentation and specialized staff interviews supported this as practice.

The policy dictates that offender victims of sexual abuse while incarcerated shall be offered timely information about and time access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate.

The policy dictates services will be provided to the victim without financial cost whether the victim names the abuser or cooperates with the investigation.

FRDC utilizes CORIZON as the medical provider and provided Part 2.4 of the contractual agreement between FRDC and CORIZON as supporting documentation denoting CORIZON's obligation to provide medical and mental health services to FRDC offenders in compliance with the PREA Standards.

The same contractual agreement denotes in the Offsite Hospital Care section, CORIZON will be responsible for and will arrange timely payment for all hospital care and related health care expenses.

Staff interviewed articulated facility practice and agency policy in regards to medical and mental health care provided in incidents of sexual abuse.

**115.83 ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.83.

FRDC offers medical and mental health evaluations and, as appropriate, treatment to all offenders who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The policy dictates follow-up services shall be provided and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or release from custody.

The policy and practice indicates that FRDC provides services consistent with the community level of care.



The policy dictates victims of sexual abuse shall be offered prophylaxis for sexually transmitted infections.

115.83(d), (e), do not apply as FRDC is an all-male facility.

The policy dictates treatment services are provided without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation.

The policy dictates an offender perpetrator of sexual abuse shall receive mental health evaluation by a qualified mental health practitioner within 60 days of learning of such abuse.

FRDC provided examples of follow up care provided to offenders as supporting documentation for this standard.

<b>115.86</b>	<b>SEXUAL ABUSE INCIDENT REVIEWS</b>
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- |   |
|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

<b>Auditor comments, including corrective actions needed if does not meet standard</b>
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Agency policy D1-8.13 addresses compliance with Standard 115.86.

The policy dictates FRDC shall conduct a sexual abuse incident review, or "debriefings," at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation was determined to be unfounded. It is documented on the PREA sexual abuse debriefing form and submitted to the PREA Coordinator, Chief Administrative Officer, and assistant division director.

The policy dictates such reviews shall be held within 30 days of a formal investigation, that the review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners, and that facilities shall implement the recommendations for improvement or document its reasons for not doing so.

FRDC provided as supporting documentation a sample review which documented all elements of Standard 115.86(d) 1-6.

Auditors concluded inclusive with supporting documentation provided by FRDC, staff interviewed articulated the importance of sexual abuse reviews and their relevance to enhance the safety of offenders and staff.

<b>115.87</b>	<b>DATA COLLECTION</b>
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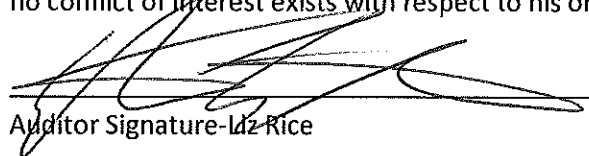
- |   |
|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

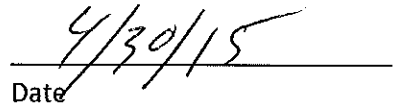
<b>Auditor comments, including corrective actions needed if does not meet standard</b>
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and can be viewed by the public. Personal information is redacted.

**AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of agency under review.

  
Auditor Signature-Liz Rice

  
Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

Name of facility: Maryville Treatment Center	
Physical Address: 30227 Highway 136, Maryville, MO 64468	
Date report submitted:	
<b>Auditor Information:</b> Ron Baker, Margie Phelps, Liz Rice	
Address: Kansas Dept of Corrections, 714 SW Jackson, Suite 300, Topeka, KS 66603	
E-Mail: <a href="mailto:ron.baker@doc.ks.gov">ron.baker@doc.ks.gov</a>	
Telephone number: 785-338-0971	
Date of facility visit: May 5-7, 2015	
<b>Facility Information</b>	
Facility mailing address: 30227 Highway 136, Maryville, MO 64468	
Telephone number: 660-582-6542	
The facility is:	
<input type="checkbox"/> Military	<input type="checkbox"/> County
<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal
<input type="checkbox"/> Private not for profit	<input type="checkbox"/> Federal
	<input checked="" type="checkbox"/> State
Facility Type: Adult Prison	
Name of PREA Compliance Manager: Gaye Colburn	Title: Deputy Warden
E-Mail Address: <a href="mailto:Gaye.Colburn@doc.mo.gov">Gaye.Colburn@doc.mo.gov</a>	Phone Number: 660-582-6542
<b>Agency Information</b>	
Name of agency: Missouri Department of Corrections	
Governing authority or parent agency: (if applicable) State of Missouri	
Physical address: 2728 Plaza Drive Jefferson City, MO 65109	
Mailing address: (if different from above)	
Telephone Number: 573-526-9003	
<b>Agency Chief Executive Officer</b>	
Name: George Lombardi	Title: Director
E-Mail Address: <a href="mailto:George.Lombardi@doc.mo.gov">George.Lombardi@doc.mo.gov</a>	Telephone Number: (573) 526-6607
<b>Agency-wide PREA Coordinator</b>	
Name: Vevia Sturm	Title: PREA Coordinator
E-Mail Address: <a href="mailto:Vevia.Sturm@doc.mo.gov">Vevia.Sturm@doc.mo.gov</a>	Telephone Number: (573) 522-1634

# AUDIT FINDINGS

## NARRATIVE:

In order to determine compliance with Prison Rape Elimination Act (PREA) standards an onsite audit was conducted of the Maryville Treatment Center (MTC) on May 5-7, 2015 by DOJ certified auditors Ron Baker, Margie Phelps, and Liz Rice.

Prior to the onsite portion of the audit, auditors provided the facility with the Auditor Notice which was posted at least 6 weeks prior to the onsite audit. The Pre-Audit Questionnaire along with other supporting documentation was provided to the auditors to review in advance of the onsite portion of the audit. Auditors appreciated the very well organized questionnaire with supporting documentation that was received and reviewed prior to the onsite visit.

The auditors reported to MTC on 05/05/2015 at 08:30 hours to complete a tour of the facility. The tour was led by Deputy Warden of Offender Management and state PREA Coordinator. The tour included all areas outside of housing units where inmates may be present and several housing units, auditors returned to all housing units for interviews. Auditors were able to observe staff and offender interaction during the tour and noticed the positive culture among staff. Offender reaction indicated that that this positive staff interaction is common place in this facility.

During the onsite audit the PCM was very responsive to auditor's questions and provided additional supporting documentation for auditors as needed.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The Maryville Treatment Center (MTC) is located at 30227 Highway 136, Maryville, MO. MTC opened in 1996 for 325 offenders and was formerly a school operated by Sisters of St Francis. In 1998 an expansion increased the population to 525 offenders. This facility is a long term treatment facility dedicated to providing drug and alcohol treatment in a therapeutic community model.

Number of standards exceeded: 0

Number of standards met: 43

Number of standards not met: 0

Number of standards not applicable: 0

<b>115.11</b>	<b>ZERO TOLERANCE OF SEXUAL ABUSE AND SEXUAL HARASSMENT; PREA COORDINATOR</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)	
<input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)	
<input type="checkbox"/> Does Not Meet Standard (requires corrective action)	

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p><b>D1-8.13 Offender Sexual Abuse and Harassment Effective Date: December 26, 2014</b></p> <p>The agency has written policy D 1-8.13 mandating zero tolerance towards all forms of sexual abuse and sexual harassment. It outlines prevention, detection and responding to reports and mandates more specific procedures at the facility level.</p> <p>The PREA Coordinator and PREA Compliance Manager stated that they have sufficient time and authority to develop and oversee compliance and each facility has a designated PREA Compliance Manager. The PREA Coordinator reports directly to agency Legal Counsel (see MDOC org chart dated June 2014), and the PREA Compliance Manager, who is also the Deputy Warden of Offender Management, reports directly to the Warden (see MTC org chart).</p>	
<b>115.12</b>	<b>CONTRACTING WITH OTHER ENTITIES FOR THE CONFINEMENT OF INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>MTC does not contract with other entities for the confinement of offenders.</p> <p>The MDOC, as parent agency, contracts with 4 community confinement facilities, although none of them are specifically tied to this facility.</p> <p>The agency contract administrator draws up the contracts, while the probation/parole division monitors compliance. Current contracts require the facilities to complete and be PREA compliant to include a PREA audit this year. Additionally, probation and parole staff conducts compliance audits every 6 months.</p>	
<b>115.13</b>	<b>SUPERVISION AND MONITORING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>MDOC staffing analysis completed in 2009. Facility completes annual staffing plan evaluation: "The purpose of this staffing plan evaluation is to ensure that custody staff are deployed in a manner which provides a safe, secure environment for staff and offenders in accordance with PREA standards and established staffing guidelines."</p> <p>2014 Custody Staffing Plan dated March 2, 2015 completed by Dusty Jones, Chief of Custody- Maryville Treatment Center. "A review of available data on the reported events did not indicate the necessity to alter operational functions of MTC. The incidents were quickly responded to and the alleged victims were appropriately protected. With the limited data available any alteration to current operations would be counterproductive and potentially detrimental."</p> <p>MTC has 4 total housing units consisting of 3 general population units, 1 dedicated segregation unit (housing unit 1). MTC has 92 authorized Correctional Officer 1 positions, and a total combined custody force of 114 staff members.</p> <p>The minimum daily total staffing for each shift has been established as follows:</p> <ul style="list-style-type: none"> <li>• 1<sup>st</sup> Shift: 14</li> <li>• 2<sup>nd</sup> Shift:20</li> <li>• 3<sup>rd</sup> Shift: 16</li> </ul> <p>There were no incidents of shifts operating below these minimum staffing numbers in the past 12 months.</p>	
<b>115.14</b>	<b>YOUTHFUL INMATES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	

<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p><b>MTC does not house youthful offenders.</b>  Agency policy D1-8.13 prohibits the placement of youthful offenders in a housing unit in which they would have sight, sound, or physical contact with any adult offender through the use of a shared dayroom or other common space, shower area, or sleeping quarters.  In assessing the compliance at the agency level, auditors noted that State of Missouri regulation, Chapter 217 Department of Corrections Section 217.345, prohibits the placement of youthful offenders with adult offenders and requires physical separation and separate housing units. Institutional Services Procedure Manual, IS5-1.1 Diagnostic Center Reception and Orientation, outlines the procedure for notification, transportation, and housing of youthful offenders in the event one is admitted. Institutional Services Procedure Manual, IS5-3.1 Offender Housing Assignments, states, "youthful offenders will only be housed with other youthful offenders (standard operating procedures (SOP) will be developed to specify how such housing assignments will be made)."</p>	
<b>115.15</b>	<b>LIMITS TO CROSS GENDER VIEWING AND SEARCHES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p><b>IS20-1.3 Searches effective December 1, 2014:</b> IS20-1.3 addresses sections (a),(c), (d), (e) and (f) for offender searches. Section (b) is N/A - MTC does not house female offenders. Documentation provided indicated that MTC had one incident in which a female officer was used on a forced cell move that involved a strip search. Corrective action was taken to ensure that a similar incident does not occur in the future.</p>	
<b>115.16</b>	<b>INMATES WITH DISABILITIES AND INMATES WHO ARE LIMITED ENGLISH PROFICIENT</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Documentation was provided that list staff fluent in 15 languages that are available to translate as well as links to contracted translation services for written and spoken words and American Sign Language. PCM reports that "Maryville Treatment Center has not utilized inmate interpreters. " in past 12 months  MDOC has established procedures, in policy D1-8.13, for disabled and limited English proficient offenders to benefit from all aspects of their PREA efforts. PREA brochures and acknowledgement forms are available in several languages and posters are available in English and Spanish. There is also a brochure available in Braille for blind offenders. Auditors noted Spanish and English signs posted throughout the facility.</p>	
<b>115.17</b>	<b>HIRING AND PROMOTION DECISIONS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>MDOC policy D1-8.13 as well as facility policy SOP D1-8.13 prohibits the hiring or promoting of anyone that has engaged in sexual abuse with an offender in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution; has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied</p>	

threats of force, coercion, or if the victim did not consent or was unable to consent or refuse; or has been civilly or administratively adjudicated to have engaged in sexual activity by force, overt or implied threats of force, coercion, or if the victim did not consent or was unable to consent or refuse. These policies also mandate the consideration of sexual harassment in determining whether to hire or promote.

MDOC policy D2-2.2 Background Investigations further addresses background checks. This policy explicitly outlines all elements required for background investigations of all staff members (which is defined to include permanent, part-time, temporary, hourly, per diem employees and contractors, volunteers, and student interns). Part of this extensive background investigation is a criminal records check by running a query through the Missouri Uniform Law Enforcement System (MULES) and the National Criminal Information Center (NCIC) system. It also specifies, for promotions and other appointments, that “a check will be conducted on the active employee through Central Office Human Resources to inquire if there has been any formal discipline for sustained allegation(s) of sexual abuse and/or harassment of an offender or resident. All sustained allegations will be considered by the department before an employee is promoted or considered for other appointments.”

Both agency and facility policy (D1-8.13 and D2-2.2) as well as the employment application assert that material omissions are grounds for termination and address the contacting of previous institutional employers. MDOC Department Procedure Manual D2-11.14 Annual Employment Requirements asserts that criminal history checks are conducted annually, congruent to the employee’s birth month.

Auditors ascertained, regarding the release of information about former employee misconduct, that the agency is able to provide such information if the former employee were to be charged with offender sexual abuse (as it would be a public record). They would be prohibited in providing information on sustained administrative cases, however, unless they had obtained the written consent of the former employee.

Auditors randomly pulled employee files; each contained records of background checks and the auditor was also provided the compilation of contractor background checks to review as well. Documentation of promoted employees also contained internal inquiries regarding misconduct involving sexual abuse or sexual harassment. This information along with the interview conducted with the personnel clerk showed the facility is in compliance with 115.17.

#### **115.18 UPGRADES TO FACILITIES AND TECHNOLOGY**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

During CY2014, there were no significant facility modifications or alterations to the physical plant.

#### **115.21 EVIDENCE PROTOCOL AND FORENSIC MEDICAL EXAMINATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

D1-8.8 Evidence Collection, Accountability and Disposal Effective Date: August 28, 2014

There were no incidents during this reporting period that required forensic exam. MTC has a contract with St Francis Hospital in Maryville and Northwest medical Center in Albany, MO to conduct SAFE/SANE exams. Copies of MDOC and MO Hwy Patrol evidence handbooks were provided to provide evidence of compliance with this standard.

#### **D1-8.13 Offender Sexual Abuse and Harassment G. 3.**

“Health services staff members should screen victims for obvious physical trauma, and at that time provide emergency medical care.

a. If an allegation of offender sexual abuse is made within 72 hours of the event and consists of penetration of the mouth, anus, buttocks, or vulva, of any kind, however slight, by hand, finger, object instrument, or penis, the victim should be transported to the community emergency room with a sexual assault forensic examiner (SAFE) or sexual assault nurse examiner (SANE), when

possible, for gathering of evidence.

b. If it has been greater than 72 hours since the alleged abuse, and the alleged victim has not showered, they should be transported to the community emergency room with a sexual assault forensic examiner (SAFE) or sexual assault nurse examiner (SANE), when possible for gathering of evidence.” MDOC was unable to secure contracts with advocacy centers, they have provided documentation that shows the Chaplin rotation used to provide victim advocacy as needed. Advocacy training was provided by Missouri Coalition against domestic violence and sexual assault.

<b>115.22</b>	<b>POLICIES TO ENSURE REFERRALS OF ALLEGATIONS FOR INVESTIGATIONS</b>
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- |   |
|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.13 Offender Sexual Abuse and Harassment Page 20 of 28 Section H**

**D1-8.4 Administrative Inquiries**

**D1-8.1 Investigation Unit Responsibilities and Actions**

A copy of MTC Coordinated Response Protocol was provided to auditors. Supporting documentation included examples of staff following CRP when reports have been received.

<b>115.31</b>	<b>EMPLOYEE TRAINING</b>
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|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.13 Offender Sexual Abuse and Harassment Page 8 of 28 Effective Date: December 26, 2014**

**Covers mandatory staff training**

MTC does not house female offenders. MTC has not had any transfers of staff from facilities housing the opposite gender. Basic and refresher training modules were reviewed and meet the required standard. A review of a random sample of training files was completed and showed 100% of those reviewed received required training. Specialized staff and random staff interviews indicate that staff has a good understanding of their responsibilities as first responders and some common behaviors to watch for that indicate possible sexual abuse. Staff at MTC are very invested in complying with the PREA standards.

<b>115.32</b>	<b>VOLUNTEER AND CONTRACTOR TRAINING</b>
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- |   |
|---|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)   |
| <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) |
| <input type="checkbox"/> Does Not Meet Standard (requires corrective action)  |

**Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.13 Offender Sexual Abuse and Harassment Page 8 of 28 Effective Date: December 26, 2014**

e. Part-time Employees/Volunteers/Contract Staff Members/Vendors:

(1) All part-time employees, volunteers and contract staff members shall receive PREA specific training to their classification as determined by the appropriate division director and chief of staff training.

(2) Vending contractors shall be escorted by a staff member at all times or shall receive PREA training prior to entering the facility.

\*\*\*SOP ADDITION: Vending contractors will be escorted by a staff member at all times.

(3) Contracted residential facilities shall ensure all staff are trained on PREA as outlined in the residential contract.

(4) Work release supervisors shall receive specific PREA training during their offender work release procedure training.



A roster of volunteer training was reviewed and 2 volunteers were interviewed. The lessons plans for volunteer training were reviewed by auditors.

#### **115.33 INMATE EDUCATION**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.13 Offender Sexual Abuse and Harassment** and April 2012 memo from Dave Dormire, Director Division of Adult Institutions. Copy of PREA brochure provided to auditors. Auditors were able to sit in on an offender education session at intake. A random sample of offender files were reviewed and documentation was in place to show that offender education was occurring that meets the standard.

A recent change to this process has been implemented that appears to better provide the education and to document the process. Upon arrival at Maryville Treatment Center, offenders participate in "intake". The offenders sit together in a group and case managers provide them with a PREA brochure and give a brief overview of what PREA is about. The offenders sign an acknowledgment form indicating they have read the brochure and discussed PREA with Classification Staff.

The following Monday, any offenders who arrived the week before will be called together to watch the PREA video. The video provides a more detailed explanation of PREA and the Department of Correction's stance of zero tolerance of sexual abuse and harassment. During the video the offenders have the opportunity to discuss any issues and concerns with staff thus providing a comprehensive education.

The PREA brochure is also available in Braille and there are posters in English and Spanish throughout the facility.

#### **115.34 SPECIALIZED TRAINING: INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

D1-8.1 Investigation Unit Responsibilities and Actions Effective Date: September 19, 2014  
Training modules that were developed 9/24/2012 were reviewed and contained required elements.  
Investigator McGee was interviewed.

**D1-8.13 Offender Sexual Abuse and Harassment Page 9 of 28 Effective Date: December 26, 20145.** PREA Specialized Training:

- a. Medical and mental health staff members shall receive annual specialized PREA training.
- b. All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training.

#### **115.35 SPECIALIZED TRAINING: MEDICAL AND MENTAL HEALTH CARE**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

#### **Auditor comments, including corrective actions needed if does not meet standard**

**D1-8.13 Offender Sexual Abuse and Harassment Page 9 of 28 Effective Date: December 26, 20145.** PREA Specialized Training:

- a. Medical and mental health staff members shall receive annual specialized PREA training.
- b. All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training.

<b>115.41</b>	<b>SCREENING FOR VICTIMIZATION AND ABUSIVENESS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <p>The policy and procedure manual provided in pre-audit documentation, and also reviewed during interviews, included all of the elements of this standard. Interviews with staff and offenders found:</p> <ul style="list-style-type: none"> <li>-During interviews with staff they were familiar with this classification process; they assign all offenders as Alpha (aggressor), Kapa (no issue) or Sigma (victim, need to be kept safe). Information from the screening is kept in a data base and is updated upon admission to this facility.</li> <li>-Interviews with Corrections Case Managers (CCM) (who do the 72-hour and 30-day assessments at this facility) revealed that they are very thorough; they described examples of when the review caused the CCM to discuss changes in classifications based on behavior since admission to prison; and how the information gained during this assessment was useful in managing the offender. -Most frequently the assessment is done by the CCM within 24 hours, the morning after admission. When the assessment is done, it is entered into a database. A support staff weekly tracks the assessments, and sends reports to CCMs on when the 30-day reassessment is due.</li> <li>-During the audit a report was provided from what is called the AIRA Assessment system, where 72-hour and 30-day assessments are done and tracked. All 72 hour assessments had been completed timely. In all but .009% of the cases 30-day assessments were completed within 30 days, and in the three instances that made up the .009% late rate, explanations were given. The practice is for the support staff to report this promptly to the Deputy Warden who addresses the issue as needed.</li> <li>-Specific examples were given during CCM interviews of behavior during the first 30 days impacting classification/assignments. Again, during the 30-day assessment the CCMs are very thorough in this assessment, conduct research about any information in the data system or file; and use this assessment to get a good sense of the offender's risk, as an aggressor or victim.</li> <li>-In pre-audit documentation the screening instrument used was provided; and during interviews with CCMs, they had the screening instruments readily available; and were well-versed in the instrument. The instrument addresses all elements required by this standard. (Detention solely for civil immigration purposes does not apply at this facility.)</li> <li>-In addition to the 72-hour and 30-day assessments, the policy and procedure manual specifically calls for incident-driven rescreening, and during interviews CCMs described this as the practice, and occurs for instance if there is a threat or incident of abuse, or an offender is in protective custody for a period.</li> <li>-In interviews with offenders, they responded to questions indicating they were assessed, they were familiar with the issues addressed in the assessment; they had conversations with their case workers about the issues covered by the assessment; and no one reported they were penalized or threatened with any penalty based upon their level of participation in the discussion.</li> <li>-Interviews with staff and observation during the tour reflected that those staff who need to know about the Alphas and Sigmas for housing, program and work assignments have access to the information; very frequent updates; and maintain the information physically out of viewing of any offenders.</li> </ul>	
<b>115.42</b>	<b>USE OF SCREENING INFORMATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> <p>Documentation provided during the pre-audit process reflects policy and procedure that requires use of the classification to assist in determining appropriate housing, programs and work assignments to ensure offender safety, institutional security, and compliance with PREA guidelines. Also staff members who supervise offenders in required activity assignments are required to use the classification score to monitor offenders. Interviews and observations during the tour also found:</p> <ul style="list-style-type: none"> <li>-Alphas and Sigmas are not housed in the same area; this is a treatment facility (therapeutic community) and each open bay is a "family" for treatment purposes; thus staff throughout identified that it is important that these two groups not be housed in the same bay. We were shown housing plans and assignments that supported this conclusion.</li> <li>-All work supervisors are aware of classification, and Alphas and Sigmas are permitted to work on the same work detail/in the same area only when there is direct supervision; the most common practice is not to have them on the same work crew; it was reported that occasionally it is unavoidable, but it is only done with direct supervision. During the tour and when moving through the facility to conduct interviews, it was observed that inmate activity is closely monitored in this facility.</li> <li>-Alphas and Sigmas can be in the same group for programming that is done above and beyond the substance abuse treatment done by "families." Those making these group assignments were interviewed; they all reported two things: First, there is very</li> </ul>	

direct and close supervision and staff presence during all these programs; we observed this during the tour, with a high ratio of program staff (both contract and DOC) to the program participants; and this was reported in detail during interviews. Second, during interviews staff identified occasions where even with the close supervision it was felt there could be some challenge for a Sigma to participate in a group with an Alpha, so it was ensured there was no placement of the Sigma in a group with an Alpha. Documentation provided during the pre-audit process reflects policy and procedure that requires considering the health and safety needs of a transgender or intersex offender in housing and program assignments case by case; all of the elements of this standard are included in the policy. The policy calls for the formation of a Transgender Committee including the health services administrator, medical director, PREA coordinator, and others, to ensure compliance.

- This facility has had no transgender or intersex offender in the 12 months preceding the audit.
- In interviews staff articulated their understanding of the policy.
- A sample of the policy being followed in another facility was provided as part of documentation.

#### **115.43 PROTECTIVE CUSTODY**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Documentation provided pre-audit reflects all of the elements of this standard are included in policy and procedure. Documentation was provided showing two examples in the 12-month period preceding the audit where the policy was followed, with temporary placement in segregation; with review within 30 days in one case (the offender was rehoused before 30 days in the other case); and with a specific statement of why this was necessary for the offender's protection. Policy reflects that the offender has access to some programming and privileges; and the facility documents what opportunities were limited, duration and reasons. Interviews with staff indicated staff awareness of the need to consider any other housing alternative to involuntary segregation.

#### **115.51 INMATE REPORTING**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Documentation provided pre-audit reflects all of the elements of this standard are covered in policy and procedure. Also a Memorandum of Agreement was provided between the Missouri DOC and the Department of Public Safety regarding reporting of sexual abuse. As well, copies of brochures and posters were provided, and these were seen prominently throughout the facility during the audit. Documentation also reflected that main room staff at this facility were directed on not opening any mail addressed to Department of Public Services, and to maintain strict confidentiality of any offender who addressed mail to that agency.

- Offenders can report by calling a hotline; by writing the Department of Public Safety, Crime Victims Services Unit, by telling or writing any staff member, private or anonymously, or through a third party.
- These options are reflected in an Arrival Packet provided to offenders upon admission; through a brochure that is given to the offender upon arrival at the facility; through a video that has been recently updated, through posters seen throughout the facility including by every offender phone; through an intake at admission to this facility (one of which was observed during the audit).
- During the tour and while in the facility for staff interviews, several times audit team members checked the phone line by calling it, and it worked, and a message could be left without any identifying information.
- During staff interviews they all expressed these various options for reporting.
- During inmate interviews they all expressed many of these options for reporting.
- During inmate interviews they expressed awareness of the video, giving specific details from the video.
- Because of the structure of the "families" for the therapeutic community, and because of some limits on phone privileges in the first few days of admission, offenders were specifically questioned about access to the phone line, and their answers indicated that any limits on phone access, or requirement of seeking approval through the therapeutic community, are exempted for PREA issues, which are to be treated as an emergency; inmates expressed being comfortable with their understanding that they could access the PREA hotline at any time, without seeking approval from anyone.

<b>115.52</b>	<b>EXHAUSTION OF ADMINISTRATIVE REMEDIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that the grievance policy has sections related to PREA which include all of the elements of this standard. The facility also provided a PREA Grievance Flow Chart for Sexual Abuse Grievances Only reflecting compliance with this standard. -The Corrections Case Manager who handles grievances for this facility was interviewed; she articulated a good understanding of the requirements of this standard and how a PREA grievance would be handled to comply with this standard. -One grievance had been filed in the 12-month period preceding the audit related to PREA; a review of the file reflected that the policy and standard had been followed. From the filing of the grievance to a resolution which the offender indicated was satisfactory took 38 days. -Offenders are informed in the Arrival Packet at the facility that they have the grievance process as an option and that the process will be expedited and that the offender will not be required to use any informal grievance process or attempt to resolve the incident with staff. -The facility has established a grievance-tracking process for PREA grievances specifically as a way to ensure the flow chart and process established is followed. -Interviews with inmates reflected they were aware they could access the grievance process for PREA reports, and they believed it would be treated as an emergency grievance with a quick response.	
<b>115.53</b>	<b>INMATE ACCESS TO OUTSIDE CONFIDENTIAL SUPPORT SERVICES AND LEGAL REPRESENTATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that policy and procedure include the elements of this standard, with specific provisions for the two organizations which have agreed to provide outside confidential victim advocacy and support services, and requiring that posters with contact information be available in housing units, chapel, library and other various locations in the facility. -Numerous efforts have been made to engage other organizations, and these efforts have been documented; funding for local organizations is the main barrier. -During the tour and otherwise while in the facility during the audit, postings with name, address, and phone number (including specifically how to make the calls) for the two organizations that have agreed to provide outside confidential victim advocacy and support services were observed in the living unit, the library, the chapel, visiting, and other places in the facility. -The postings inform the offenders that the phone calls may be monitored. -Interviews with offenders indicated they were aware of these services; some specifically commented that they knew the names of the organizations very well because they saw the postings whenever they made a phone call due to the location of the postings. -Contact information for these outside organizations is included in fliers/brochures throughout the facility; by policy and per interviews with staff by practice the flier is made available to any offender placed in temporary segregation.	
<b>115.54</b>	<b>THIRD-PARTY REPORTING</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that the Missouri DOC includes a place on its public website with information about	

PREA, and with a specific email address to make a third party report of sexual abuse or sexual harassment (along with a phone number or mailing address). See <http://doc.mo.gov/OD/PREA.php>. Interviews with staff indicated they are aware offenders can report through a third party. Interviews with inmates indicated they are aware they can have a person outside report for them, such as a family member, an attorney, a mentor, a pastor, or a friend.

#### **115.61 STAFF AND AGENCY REPORTING DUTIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Documentation provided pre-audit reflects that Missouri has a statute requiring any employee of the department who has reasonable cause to believe an officer in a correctional center has been abused to report it immediately in writing to the Director of the Missouri DOC, see Missouri Revised Statutes Section 217.410.1. The policy and procedure of the agency also requires staff to report, however the information is received.

-Staff interviews indicated that all staff are aware of the duty to report, whether they receive information in writing, verbally, anonymously, or through a third party; and that the duty to report is immediate, and they indicated they would do so both verbally and in writing, to their supervisor.

Policy also limits dissemination of sensitive information related to offender sexual abuse; and requires that medical and mental health staff shall inform offenders of their duty to report. Staff are prohibited from revealing any information related to an allegation of offender sexual abuse or harassment other than to the extent necessary to make treatment, investigation, and other security and management decisions.

-Staff interviews with uniformed staff and case managers indicated they are all aware of the duty not to share any information about an incident of offender sexual abuse or harassment except as necessary to respond to the event and protect the offender. Documentation provided pre-audit reflects that medical and mental health staff at this facility have not had any situation requiring a report of any sexual abuse.

-Interviews with medical/mental health staff reflected their understanding of the duty to report, and that they should and would inform the offender of this duty and this limit on confidentiality at the initiation of services.

-There are no offenders under the age of 18 at this facility. Agency policy requires that if an offender is under the age of 18, a health service staff member shall report the allegation to the designated local Children's Division, Department of Social Services under applicable mandatory reporting laws. Missouri Revised Statutes Section 630.005 mandates this reporting.

Policy, posted notices, information given to offenders at intake, and the Coordinated Response to Offender Sexual Abuse protocols all reflect that the facility will report all allegations of sexual abuse and sexual harassment, including third-party and anonymous, to the facility's designated investigator.

-Interviews with staff indicated they understood thoroughly that all reports, from whatever source, in whatever form, were to be reported to the supervisor immediately. Interviews with supervisors indicated they understood these reports were to be forwarded to the facility's investigator (one on site, one remote), with no screening out of any for any reason.

-The facility reported they had not received any anonymous or third-party reports to forward for investigation.

#### **115.62 AGENCY PROTECTION DUTIES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Documentation provided by the facility pre-audit reflects that policy and procedure require an immediate response if the agency learns that an inmate is subject to a substantial risk of imminent sexual abuse.

-Interviews with uniformed staff and case workers reflected their understanding that if they had information from any source regarding an imminent threat, they should respond immediately. Corrections Officers indicated they would immediately notify their shift supervisor; shift commanders indicated they would respond immediately including addressing housing, notifying the investigator and PREA coordinator, and using the coordinated response protocols as needed.

-This facility has not had any offenders placed in segregated housing due to imminent risk of sexual abuse.

<b>115.63</b>	<b>REPORTING TO OTHER CONFINEMENT FACILITIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<p><b>Auditor comments, including corrective actions needed if does not meet standard</b></p> <p>Documentation provided pre-audit reflects that the policy and procedure is that if an allegation that an offender was sexually abused at another Missouri DOC facility is made, the facility will initiate a coordinated response, and all relevant information forwarded to the site coordinator of the facility where the abuse was alleged to have occurred; if abuse is alleged to have occurred at a facility outside of the Missouri DOC, a coordinated response is initiative and forwarded to the PREA coordinator within 72 hours, and the PREA coordinator ensures notification is made to the outside agency within 72 hours.</p> <p>-The facility provided documentation of three instances of a report of sexual abuse occurring in an outside facility. In each instance, the event was alleged to have occurred in a jail, and the Sheriff in charge of the jail was notified within 72 hours.</p> <p>-The facility has not received any allegations from other confinement facilities.</p> <p>-Interview with the Deputy Warden (also the PREA Coordinator for the facility) reflected her understanding that notification was to occur of any event alleged to have occurred in another facility; and that a coordinated response would occur if a report was made of an event in another facility or of an alleged event in this facility.</p>	
<b>115.64</b>	<b>STAFF FIRST RESPONDER DUTIES</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<p><b>Auditor comments, including corrective actions needed if does not meet standard</b></p> <p>Documentation provided pre-audit reflected that policy and procedure include all of the elements of this standard.</p> <p>-The facility has established an event check list for a PREA allegation notification, and provided examples of completed check lists from when allegations occurred.</p> <p>-The facility provided a copy of training that is provided to staff regarding staff first responder duties, and documentation that staff had completed the training.</p> <p>-Staff interviews reflected a thorough awareness by officers of first responder duties. Corrections officers have been provided a laminated short check list that is affixed next to their identification with steps, as a quick reminder. Clearly the officers were well versed in their first responder duties. They were able to give very specific steps regarding notification; regarding preserving physical evidence (when applicable); and regarding separating the alleged victim and abuser.</p> <p>-Staff interviews with case workers reflected their awareness that they should request that the alleged victim not take any actions that could destroy physical evidence, and then immediately notify security staff.</p>	
<b>115.65</b>	<b>COORDINATED RESPONSE</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<p><b>Auditor comments, including corrective actions needed if does not meet standard</b></p> <p>Documentation provided pre-audit reflects that policy and procedure include a written institutional plan for a coordinated response to an incident of sexual abuse, among staff first responders, medical and mental health practitioners, investigators and facility leadership. The coordinated response is detailed, clear, and explicit; and one has been developed and implemented for penetration events and non-penetration events. The importance of the coordinated response has been emphasized to staff verbally on an ongoing basis, and in writing, by senior department and facility staff. A check list has been developed and used to ensure the protocols of the coordinated response are followed.</p> <p>-Samples of the use of the check list were provided.</p> <p>-Interviews with first responders, medical, mental health, investigator and facility leadership staff all indicated their familiarity with the coordinated response, the importance of it, and the use of it.</p>	



-Interviews with offenders indicated that they are aware the facility is serious about PREA; and that there will be a response promptly to any allegation.	
<b>115.66</b>	<b>PRESERVATION OF ABILITY TO PROTECT INMATES FROM CONTACT WITH ABUSERS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that policy and procedure require that the department shall not enter into or renew any collective bargaining agreements or other agreements that limit the department's ability to remove alleged staff sexual abusers from contact with any offender or resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted. Current labor agreements were provided, one with probation/parole and one with corrections officers, both of which expressly give management the right to hire, assign, reassign, transfer, promote and to determine hours of work and shifts and assign overtime.	
<b>115.67</b>	<b>AGENCY PROTECTION AGAINST RETALIATION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that policy and procedure require that immediately following any reported incident of sexual abuse or harassment, monitoring for retaliation shall be conducted, with specific steps and time frames consistent with this standard. -The facility has established a protocol/checklist for assessment of retaliation status -The facility provided samples of documentation of monitoring following a reported incident -Interviews with staff reflected their understanding that retaliation is prohibited -Interviews with offenders found no reported instance of retaliation, and their understanding they were to be free from retaliation -Interviews with Deputy Warden and staff charged with monitoring reflected an understanding and implementation of this policy and protocol.	
<b>115.68</b>	<b>POST-ALLEGATION PROTECTIVE CUSTODY</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<b>Auditor comments, including corrective actions needed if does not meet standard</b> Documentation provided pre-audit reflects that the policy and procedure is that if there is an allegation of sexual abuse, the shift commander is to ensure the offender is housed in the least restrictive housing available to ensure safety. The policy includes all elements of 115.43. -Interviews with segregation and senior staff at the facility indicate that offenders are not routinely placed in segregation when an allegation of abuse occurs. See further details at 115.43 above. -This facility has not had any offenders placed in segregation housing due to imminent risk of sexual abuse.	
<b>115.71</b>	<b>CRIMINAL AND ADMINISTRATIVE INVESTIGATIONS</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)	

☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D 1-8.1 and D 1-8.4 dictate compliance with Standard 115.71.

Investigators are trained to collect and preserve evidence, interviewing, report writing and continuing an investigation to prosecution when warranted. Investigation reports are well documented and are maintained by the agency. The PREA Coordinator has a tracking system which accounts for each referral and the status thereof.

MTC provided investigations for pre-audit review as supporting documentation. Auditors also reviewed investigation files on-site. Investigations reviewed indicated they were done in a prompt, thorough and objective manner.

The agency investigator interviewed was able to articulate elements of this standard and provided elements of agency training and investigations protocol. The investigator interviewed was also able to articulate procedures for counseling with prosecutors and outside law enforcement agencies.

**115.72 EVIDENTIARY STANDARDS FOR ADMINISTRATIVE INVESTIGATIONS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility does not employ a standard higher than a preponderance of evidence as proof in determining whether allegations of sexual abuse or sexual harassment are substantiated. Review of the investigations supported this as practice.

**115.73 REPORTING TO INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)  
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)  
☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates facility compliance with Standard 115.73.

The policy dictates, upon the conclusion of an investigation, the facility informs the offender whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

115.73(b) is not applicable to this audit.

The policy dictates that following an allegation involving staff-on-offender sexual abuse, (unless determined to be unfounded) the facility informs the offender when; the staff member is no longer posted within the offender's living unit, the staff member is no longer employed at the facility, the agency learns the staff member has been indicted on a charge related to sexual abuse, or the agency learns the staff member has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing this offender notification.



The policy dictates that, following an offender's allegation he/she has been abused by another offender, the facility informs the alleged victim when; the agency has learned the alleged abuser has been indicted on a charge related to sexual abuse within the facility, or the agency learns the alleged abuser has been convicted on a charge related to sexual abuse within the facility. The PREA Site Coordinator is charged with providing the notification to the offender.

The policy dictates the notifications shall be done in writing.

The auditors viewed examples of this policy being followed.

<b>115.76</b>	<b>DISCIPLINARY SANCTIONS FOR STAFF</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 and Policy D2-11.10 dictate compliance with Standard 115.76.

The policy dictates staff are subject to disciplinary sanctions up to and including termination for violations of agency sexual abuse or sexual harassment policies.

The policy dictates termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse.

Policy D2-11.10 Staff Member Conduct addresses incidents of staff misconduct of a sexual nature and includes sexual abuse and harassment of offenders.

Policy D1-8.13 dictates terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

When the personnel clerk was interviewed she indicated the policy would be followed and staff are aware of the policy. MTC reported there were no incidents to report to relevant licensing bodies during this audit period.

<b>115.77</b>	<b>CORRECTIVE ACTION FOR CONTRACTORS AND VOLUNTEERS</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
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**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.77.

The policy dictates contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to law enforcement and relevant licensing bodies.

The policy further dictates the facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in cases of any other violations.

Policy D2-13.1 Volunteers addresses conduct pertinent to volunteers and dictates any allegation of sexual abuse or sexual harassment will be referred for investigation.

MTC reported there were no incidents involving a contractor or volunteer to report to law enforcement or relevant licensing body during this audit period.

#### **115.78 DISCIPLINARY SANCTIONS FOR INMATES**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.78.

The policy dictates offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding the offender engaged in offender-on-offender sexual abuse.

The policy dictates sanctions shall be commensurate with the nature of and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories.

The policy dictates if an offender's mental disability or mental illness contributed to his behavior this should be considered when determining sanction(s).

The policy dictates if found guilty, the offender shall be referred for appropriate treatment to include therapy or counseling by mental health staff.

The policy dictates an offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent.

MTC provided MDOC Conduct and Rules Sanctions IS19-1.1 addressing consensual and non-consensual sexual activity of offenders.

#### **115.81 MEDICAL AND MENTAL HEALTH SCREENINGS; HISTORY OF SEXUAL ABUSE**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

##### **Auditor comments, including corrective actions needed if does not meet standard**

Agency policy IS11-32 Receiving Intake Unit and D1-8.13 Offender Sexual Abuse and Harassment address compliance with Standard 115.81.

Both policies dictate that if an offender discloses victimization or perpetration of sexual abuse whether it occurred in an institutional setting or in the community, staff offer a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. The Adult Internal Risk Assessment (PREA screening) documents whether a mental health referral was accepted or declined and, if accepted, prompts staff to complete the mental health referral.

Information related to sexual victimization or abusiveness that occurred in an institutional setting is strictly limited to medical and mental health practitioners and other staff, as necessary, to inform treatment plans and security management decisions, including housing, bed, work, education, and program assignments or as otherwise required by state or local law. Both policies dictate medical and mental health practitioners shall obtain informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18.

MTC also provided medical and mental health PREA event logs and offender confinement records as supporting documentation for this standard.

<b>115.82</b>	<b>ACCESS TO EMERGENCY MEDICAL AND MENTAL HEALTH SERVICES</b>
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| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
|--|

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.82.

The policy dictates that offenders shall receive timely, unimpeded access to emergency medical treatment and crisis intervention services. The scope of such services is to be determined by medical and mental health practitioners according to professional judgment. Documentation and specialized staff interviews supported this as practice.

The policy dictates that offender victims of sexual abuse while incarcerated shall be offered timely information about and time access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate.

The policy dictates services will be provided to the victim without financial cost whether the victim names the abuser or cooperates with the investigation.

MTC utilizes CORIZON as the medical provider and provided Part 2.4 of the contractual agreement between MTC and CORIZON as supporting documentation denoting CORIZON's obligation to provide medical and mental health services to MTC offenders in compliance with the PREA Standards.

The same contractual agreement denotes in the Offsite Hospital Care section, CORIZON will be responsible for and will arrange timely payment for all hospital care and related health care expenses.

Staff interviewed articulated facility practice and agency policy in regards to medical and mental health care provided in incidents of sexual abuse.

<b>115.83</b>	<b>ONGOING MEDICAL AND MENTAL HEALTH CARE FOR SEXUAL ABUSE VICTIMS AND ABUSERS</b>
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- |  |
|--|
| <input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard)<br><input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)<br><input type="checkbox"/> Does Not Meet Standard (requires corrective action) |
|--|

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 dictates compliance with Standard 115.83.

MTC offers medical and mental health evaluations and, as appropriate, treatment to all offenders who have been victimized by sexual abuse in any prison, jail, lockup, or juvenile facility.

The policy dictates follow-up services shall be provided and when necessary, referrals for continued care following their transfer to, or placement in, other facilities, or release from custody.

The policy and practice indicates that MTC provides services consistent with the community level of care.

The policy dictates victims of sexual abuse shall be offered prophylaxis for sexually transmitted infections.

115.83(d), (e), do not apply as MTC is an all-male facility.

The policy dictates treatment services are provided without financial cost and regardless of whether the victim names the abuser or cooperates with the investigation.

The policy dictates an offender perpetrator of sexual abuse shall receive mental health evaluation by a qualified mental health practitioner within 60 days of learning of such abuse.

MTC has not had any referrals to show as examples of follow up care provided to offenders as supporting documentation for this standard.

**115.86 SEXUAL ABUSE INCIDENT REVIEWS**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy D1-8.13 addresses compliance with Standard 115.86.

The policy dictates MTC shall conduct a sexual abuse incident review, or "debriefings," at the conclusion of every sexual abuse investigation, including where the allegation has not been substantiated, unless the allegation was determined to be unfounded. It is documented on the PREA sexual abuse debriefing form and submitted to the PREA Coordinator, Chief Administrative Officer, and assistant division director.

The policy dictates such reviews shall be held within 30 days of a formal investigation, that the review team shall include upper-level management officials, with input from line supervisors, investigators, and medical or mental health practitioners, and that facilities shall implement the recommendations for improvement or document its reasons for not doing so.

MTC provided as supporting documentation a sample review which documented all elements of Standard 115.86(d) 1-6.

Auditors concluded based on supporting documentation provided by MTC and the interviews of staff who articulated the importance of sexual abuse reviews and their relevance to enhance the safety of offenders and staff that policy is being followed.

<b>115.87</b>	<b>DATA COLLECTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	
<p><b>Auditor comments, including corrective actions needed if does not meet standard</b></p> <p>Agency policy D1-8.13 addresses compliance with Standard 115.87.</p> <p>The policy describes the collection of uniform data by the Agency PREA Coordinator. Data is collected and reported on BJS Survey of Sexual Violence in addition to maintaining data in the information network (COIN) system. Policy and practice indicated that data is collected annually, at a minimum.</p> <p>MTC provided documentation of monthly incident based data for years 2013 and 2014, and the annual report by facility for 2013.</p> <p>115.87(e) does not apply to this audit.</p>	
<b>115.88</b>	<b>DATA REVIEW FOR CORRECTIVE ACTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action) <b>Auditor comments, including corrective actions needed if does not meet standard</b>	
<p>Agency policy D1-8.13 dictates compliance with Standard 115.88.</p> <p>The policy outlines the Agency PREA Coordinator's responsibilities in collecting and aggregating data and preparing an annual report, pursuant to 115.88. Data was available and was reviewed by auditors on the agency's website.</p> <p>Data is collected and used to assess and improve the effectiveness of its sexual abuse prevention, detection, and response policies, practices, and training. Problem areas are identified and corrective actions are noted on an ongoing basis. The agency prepares an annual report of its findings and corrective actions for each facility, as well as the agency as a whole.</p> <p>The report(s) compares data from previous years along with corrective actions and denotes the agency's progress in addressing sexual abuse.</p> <p>The reports are submitted and approved by the agency head, the Agency PREA Coordinator, and are provided on the agency's website. The website was reviewed by auditors and was found to be compliant with element(s) of this standard.</p> <p>The agency redacts specific material from reports when publication would present a clear and specific threat to the safety and security of a facility. The agency indicates the nature of the material redacted.</p> <p>MTC provided the MTC PREA yearly report for 2013 and the Missouri Department of Corrections yearly PREA report for 2013 as supporting documentation.</p>	
<b>115.89</b>	<b>DATA STORAGE, PUBLICATION, AND DESTRUCTION</b>
<input type="checkbox"/> Exceeds Standard (substantially exceeds requirement of standard) <input checked="" type="checkbox"/> Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period) <input type="checkbox"/> Does Not Meet Standard (requires corrective action)	

**Auditor comments, including corrective actions needed if does not meet standard**

Agency policy DI-8.13 and practice assert that data is securely retained. Data is available via website and can be viewed by the public. Personal information is redacted.

**AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of agency under review.



Auditor Signature

5/21/2015

Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

<b>Name of facility:</b>	Missouri Eastern Correctional Center		
<b>Physical address:</b>	18701 Old Hwy 66, Pacific, MO 63069		
<b>Date report submitted:</b>	December 18, 2015		
<b>Auditor Information</b>	<b>Joseph Z. Martin</b>		
<b>Address:</b>	374 New Bethel Church Road, Fredonia, KY 42411		
<b>Email:</b>	joseph.martin@ky.gov		
<b>Telephone number:</b>	270 388-1048		
<b>Date of facility visit:</b>	September 28-30, 2015		
<b>Facility Information</b>			
<b>Facility mailing address: (if different from above)</b>			
<b>Telephone number:</b>	(636) 257-3322		
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	<input type="checkbox"/> Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b>	Brenda Short	<b>Title:</b> PREA Compliance Manager	
<b>Email address:</b> Brenda.Short@doc.mo.gov		<b>Telephone number:</b>	(636) 257-3322
<b>Agency Information</b>			
<b>Name of agency:</b>	Missouri Department of Corrections		
<b>Governing authority or parent agency: (if applicable)</b>	Missouri Department of Corrections		
<b>Physical address:</b>	2729 Plaza Drive P.O. Box 236 Jefferson City, MO. 65102		
<b>Mailing address: (if different from above)</b>	Same as above		
<b>Telephone number:</b>	(573) 751-2389		



<b>Agency Chief Executive Officer:</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director
<b>Email address:</b>		<b>Telephone number:</b>	(573) 526-6607
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b>	Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b>	Vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	(573) 522-3325

## AUDIT FINDINGS

### NARRATIVE:

The site visit for the PREA Audit of the Missouri Eastern Correctional Center was conducted on September 28-30, 2015. The audit team consisted of the Audit Chair, Joe Martin, KDOC/DOJ Certified PREA Auditor with two support staff consisting of Debra Banks, KDOC/DOJ Certified PREA Auditor and David Meeks, KDOC. During the Pre-Audit phase, the team reviewed the standards and completed much of the file review prior to the site visit. Follow-up documentation requirements was provided to the team on-site.

An entrance meeting was held at the beginning of the on-site visit with the following MECC staff in attendance: Warden Jennifer Sachse, Deputy Warden/PCM Brenda Short, Deputy Warden George Hayes, Chief of Custody Sam Billingsley and Assistant Warden John Hilpert. Discussion was held of the audit team's schedule and tour plans of the facility including staff and inmates that would be interviewed.

During the three day on-site portion of the audit, the team completed necessary follow-up documentation review that was requested during the pre-audit phase, toured the institution and conducted formal staff and inmate interviews. The team interviewed 24 inmates consisting of 10 random (from each housing unit), 3 who reported sexual abuse, 5 disabled and limited English proficient, 4 who disclosed sexual victimization during risk screening and 2 LGBTI. In addition, the team interviewed 43 staff consisting of the Warden, the Compliance Manager, 4 who perform the screening for victimization and abusiveness, 1 intake, 1 charged with monitoring retaliation, 3 who supervise segregated housing, 2 who have acted as first responders, 3 volunteerers/contractors, 1 investigative staff, 7 medical/mental health, 2 human resources, 3 intermediate to higher level supervisors, 2 that sit on the incident review team and 12 random (from each shift).

### DESCRIPTION OF FACILITY CHARACTERISTICS:

The Missouri Eastern Correctional Center is a Medium security male facility located in Pacific, Missouri. It opened in September of 1981. The facility consists of four general population housing units, a programs building, the administrative segregation unit, medical clinic, gym, a garage, five wall towers, a water treatment plant and a administration building.



## SUMMARY OF AUDIT FINDINGS:

The Audit team found that staff at MECC had good knowledge of PREA and what their duties and responsibilities consisted of. Deputy Warden/PCM Brenda Short demonstrated ownership with her facilities efforts towards PREA compliance. Deputy Warden Short was knowledgeable and assisted the team with questions and providing additional documentation.

The team also found that inmates had good general knowledge of PREA that included reporting methods, services offered and knowledge of key information that was posted throughout the facility as well as videos shown on the institution's television channel.

Two standards were found to be in non-compliance. They were standards 115.15 section (d) and 115.33 sections (c) and (e). A 90 day Corrective Action plan was issued and the facility became compliant with these standards. The 90 day Corrective Action Plan was scheduled to end on December 29, 2015. MECC provided documentation requirements demonstrating compliance as had previously been described in the corrective action phase on December 18, 2015.

Corrective Action was for the facility to improve privacy partitions in the Segregation Unit to ensure the inmates had sufficient privacy when showering, train their staff on the agency policy of females entering bathrooms, cross-gender announcements in the living units, and to educate inmates that transferred into the facility that was housed in the Segregation Unit. All documentation has been received to show these practices have been institutionalized.

Each standard below will have comments/recommendations and justifications to why compliance or non-compliance was determined.

Number of standards exceeded:	1
Number of standards met:	41
Number of standards not met:	0
Not Applicable:	1

### **§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 outlines the departments process in preventing, detecting and responding to inmate sexual abuse and sexual harassment. MDOC has an agency-wide PREA Coordinator. In addition, each facility has a designated PREA Compliance Manager.

### **§115.12 - Contracting with other entities for the confinement of inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

MDOC obligates contracted entities to adopt and comply with the PREA Standards. Sample documentation of contracts verified and instrument used for on-site visits demonstrates contracted facilities are visited to check compliance.

### **§115.13 – Supervision and Monitoring**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Documentation provided that the agency considers all the components in sections (a) when reviewing MECC's staffing plan. No deviations from their plan were reported.

MECC's Annual Report was reviewed and the components from section (c) outlined and reviewed.

Policy D1 8.13 directs for supervisory unannounced rounds and prohibits staff from alerting other staff of the rounds. Interviews of supervisory staff corroborated this practice along with documentation provided.

### **§115.14 – Youthful Inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

This standard is Non-Applicable for MECC as it does not house Youthful Offenders.

### **§115.15 – Limits to Cross-Gender Viewing and Searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

This standard states that that the facility shall not conduct cross-gender strip searches or cross-gender body cavity searches except in exigent circumstances, and that policies and procedures are in place to allow inmates to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing their buttocks or genitalia. In addition, it directs for all security staff to be trained in how to conduct cross-gender pat-down searches and searches of transgender and intersex inmates in a professional and respectful manner.

Policies IS20-1.3 and D1-8.13 outlines this standard. MECC reported no instances of cross-gender strip or visual body cavity searches. Policy D1-8.13 directs that inmates be able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing the inmate's buttocks or genitalia.

MECC became complaint with this standard during the Corrective Action Phase. Additional privacy partitions were placed in the Segregation Unit to allow for inmates to have sufficient coverage from be viewed by female staff. MECC staff were trained on the agency's policy of the protocol for when female staff enter restrooms and staff were trained on the protocol for cross-gender announcements made in the living units as directed by the agency's directive.

### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1- 8.13 outlines this standard. MECC has contacts with Interpreter Services if the need arises. The facility has PREA posters along with victim advocate information posted throughout the facility. They also have braille and Spanish versions available. MECC does not use inmate interpreters for disabled or limited English proficient inmates making claims of Sexual Abuse and/or Sexual Harassment.

### **§115.17 – Hiring and Promotion Decisions**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

MDOC does not hire or promote anyone who fails to meet stipulations outlined in this standard. The state application incorporates direct language from standard. Policy D2 2.2 and a Directive from the agencies Human Resources directs practice of hiring and promoting with stipulations of this standard. The Employee Handbooks directs a continuing affirmative for employees to report this type of misconduct. In addition, criminal background checks are done for all staff annually.

Human Resources staff interviews showed good understanding of this standard along with the agencies policy and practice.

### **§115.18 – Upgrades to Facilities and Technology**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D4- 4.8 incorporates direct language from standard. MECC reported no expansions or modifications.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency utilizes investigators from the Inspector Generals office which is part of the MDOC. Policy D1-8.8 describes protocol. MECC utilizes the local hospital in their plan if a forensic exam was to be needed for inmate sexual abuse. MECC reported 2 instances of this occurrence within the last 12 months. MECC provides victim advocacy on-sight from their trained Chaplains.

Documentation review on-site showed victim advocacy was present during the forensic exams. MECC posts advocacy information throughout the facility. Inmate interviews corroborated education is given and is readily available.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard)

for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13 and D1-8.1 directs for all allegations of sexual abuse and sexual harassment to be investigated. Documentation review proved investigations are conducted appropriately and thoroughly. Staff interviews corroborated understanding of their responsibilities for referrals for criminal behaviors.

### **§115.31 – Employee Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines employee training and PREA. Lesson Plans and curriculum used covers all aspects of section (1) –(10) used in basic training and refresher training. MDOC has different lesson plans for staff working at male vs female facilities. MDOC requires acknowledgment forms from staff who complete this training and MECC keeps this documentation as it was reviewed.

Staff interviews corroborated all staff have been appropriately trained.

### **§115.32– Volunteer and Contractor Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines this standard. MECC reported 75 volunteers/contractors had received training. MECC maintains documentation of participation and acknowledgment forms are kept. Volunteer interviews corroborated they had received training and it is continued annually.

### **§115.33 – Inmate Education**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

This standard directs for inmates to be educated on the agency's zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment. In addition, the standard directs that education be given in formats accessible to all inmates, including those who are limited English proficient, deaf, visually impaired or otherwise disabled.

MECC educates newly arrived inmates of the agencies zero-tolerance regarding sexual abuse and sexual harassment and to report such incidents. MECC shows videos to new arrivals which covers all components of this standard. MECC reported 879 inmates had been educated within the last 12 months. MECC provides this education to inmates who are handicapped or disabled. Documentation and acknowledgement forms are maintained of this training.

MECC became complaint with this standard during the Corrective Action Phase. During the on-site audit it was discovered that inmates that transferred into their Segregation Unit from other facilities were not being educated on the requirements. This practice has been corrected and the PREA education process has been institutionalized for inmates transferring into the unit.

#### **§115.34 – Specialized Training: Investigations**

☒ Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

MECC exceeds this standard as their administrative and criminal investigators have received specialized training on how to conduct sexual abuse and/or sexual harassment investigations in confinement settings. The training curriculum and lesson plans used exceed the requirements outlined in this standard. Interviews with investigators showed great knowledge and experience possessed.

#### **§115.35 – Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines requirements of this standard. MECC was found to have all of their medical and mental health staff properly trained. MECC keeps documentation of this training and staff interviews corroborated they had received it.

### **§115.41 – Screening for Risk of Victimization and Abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. The facility utilizes an Internal Adult Risk Assessment as an objective screening tool. Compliance was confirmed through interviews with staff and offenders as well as documentation of the tool applied.

### **§115.42 – Use of Screening Information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harrassment and IS5-3.1 Offender Housing Assignments, covers this standard. The facility currently has one transgender inmate and utilizes a committee and policy which outlines actions to be taken to confirm compliance with this standard.

Interviews with staff showed knowledge of having separation between those offenders who were at high risk of being sexually victimized from those who were at a high risk of being sexually abusive. Staff making determinations for job and/or program assignments for high-risk inmates consider the assessment scores.

### **§115.43 – Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. The facility has had no cases of involuntary segregation for offenders at high risk. A protocol is in agency policy to address this matter if needed. Staff knew the need of considering alternate housing before the placement of alleged victims in Segregated housing.

### **§115.51 – Inmate Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. The facility provides several ways for offenders to report abuse. This was confirmed through interviews with offenders who stated they were made aware of these methods

Staff interviews confirmed that staff were aware that they could report abuse privately through the Crime Tip Hotline and in writing to the Dept. of Public Safety. Staff also confirmed that verbal or written reports to Administrative Staff were accepted.

### **§115.52 – Exhaustion of Administrative Remedies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D5-3.2 Offender Grievances covers this standard. MECC has reported no grievances have been filed in regards to sexual abuse in the last 12 months.

Interview with the Grievance Coordinator showed knowledge of the proper process for such grievances to be filed including no limitations on time to file such grievances regarding sexual abuse.

### **§115.53 – Inmate Access to Outside Confidential Support Services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. The facility has flyers posted in living units and common areas. Brochures are also provided to offenders containing this information. Offender interviews confirmed that they had knowledge of monitoring duties by staff, but most were unaware that the Chaplain was the acting Victim Advocate. The facility is making this information available to all offenders.



*It is recommended that more education be given to inmates as well as staff of the role that Chaplains play as Victim Advocacy at the facility.*

### **§115.54 – Third-Party Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Information provided on the agency website instructs on how to report third party reports to the agency. Offender interviews showed that most know about third party reporting. Staff interviews showed good knowledge possessed that 3<sup>rd</sup> party reporting is allowed and investigated normally.

### **§115.61 – Staff and Agency Reporting Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. This policy requires that all staff immediately report any information regarding an incident of sexual abuse or sexual harassment. This policy also requires staff report any incidents of retaliation immediately. Staff interviews confirmed that staff are aware of the urgency in reporting these incidents and are aware of the agency policy and keeping information confidential.

The agency also uses Policy IS11-32 Receiving Screening Intake Unit which covers the mandatory reporting laws.

### **§115.62 – Agency Protection Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Sexual Abuse and Harassment covers this standard. Staff interviews confirmed that staff were aware that they should immediately take action to protect the offender who reported the abuse.

### **§115.63 – Reporting to Other Confinement Facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. Compliance was shown through reviewed documentation and policy language which outlines the notification requirement between facilities.

### **§115.64 – Staff First Responder Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. The facility utilizes security and non-security staff as first responders and all staff have received training on first responder duties.

Staff interviews confirmed that staff were aware of their duties as a first responder and staff at the facility have a “First Responder” card which outlines what a first responder’s duties are that they have on them at all times.

### **§115.65 – Coordinated Response**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The facility utilizes an Institutional Plan that outlines a Coordinated Response to Offender Sexual Abuse. This plan covers the duties of the staff acting as first responders, investigators, supervisors, medical staff, and mental health staff.

### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

An agreement was provided in documentation review between The Missouri Dept. of Corrections Division of Adult Institutions and Missouri Corrections Officers Association. This agreement went into effect on 10/01/2014 and is effective until 09/30/2018.

### **§115.67 – Agency protection against retaliation**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. A review of documentation shows confirmation that monitoring occurs in periodic checks every 30 days up to 90 days and longer if needed.

Staff interviews confirmed that if needed, the monitoring will continue past 90 days.

### **§115.68 – Post-Allegation Protective Custody**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment covers this standard. MECC has had no occurrences where segregated housing was used to protect an inmate who has alleged to have been sexual abused. Proper protocol has been established in the policy should this need to occur.

### **§115.71 – Criminal and Administrative Agency Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policies D1-8.4 Administrative Inquiries and D1-8.1 Investigative Unit Responsibilities and Actions outlines this standard and dictates compliance. MDOC investigation division is under the jurisdiction of the Inspector General's Office. Investigators conduct both the administrative and criminal investigations. Investigators have been trained in compliance with standard 115.34. Investigations that were reviewed indicated they were done in a prompt, thorough and objective manner. The investigative reports are well documented and included examples of collection and preservation of evidence and included an example of a case that was referred for prosecution.

### **§115.72 – Evidentiary Standard for Administrative Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policies D1-8.4 Administrative Inquiries and D1-8.1 Investigative Unit Responsibilities and Actions outlines this standard and dictates compliance. The policies dictate that the facility does not employ a standard higher than a preponderance of evidence as proof whether allegations of sexual abuse or sexual harassment are substantiated. Review of the investigations supported this as practice.

### **§115.73 – Reporting to Inmate**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines the reporting requirements for this standard and dictates compliance. Interviews with staff and offenders as well as examples of notification confirmed facilities compliance with this standard.

### **§115.76 – Disciplinary sanctions for staff**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and

Harassment outlines this standard and dictates compliance. Review of investigations indicated that staff are disciplined for violating the agency sexual abuse and sexual harassment policy. Facility reported there were no incidents to report to relevant licensing bodies during this audit period.

### **§115.77 – Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policies D1-8.13 Offender Sexual Abuse and Harassment and D2-13.1 Volunteers outlines this standard and dictates compliance. Facility reported there were no incidents involving a contractor or volunteer to report to law enforcement or relevant licensing body during this audit period.

### **§115.78 – Disciplinary sanctions for inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. MDOC Conduct and Rules Sanctions IS19-1.1 policy also addresses consensual and non-consensual sexual activity of offenders. Facility provided a referral form utilized by MDOC for input/feedback from a qualified mental health practitioner in sustained cases of offender on offender sexual abuse.

### **§115.81 – Medical and mental health screenings; history of sexual abuse**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policies D1-8.13 Offender Sexual Abuse and Harassment and IS11-32 Receiving Screening Intake Center outlines this standard and dictates compliance. Facility provided documentation that showed the practice of offering follow ups for offenders that disclosed during the screening prior sexual victimization and offenders who previously perpetrated sexual abuse.

During the interviews with Medical Staff it was stated that the facility has not had any

incidents requiring them to obtain a consent form.

### **§115.82 – Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. Facility provided documentation to show timely, unimpeded access to emergency medical treatment and crisis intervention services. This included education and timely access to sexually transmitted infections prophylaxis at no cost to the inmate.

### **§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. The facility offers medical and mental health evaluations as appropriate. Facility provided examples of follow up care provided to offenders as supporting documentation for compliance of this standard.

### **§115.86 – Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. The facility provided documentation of Incident Reviews (debriefings). The reviews are occurring normally within thirty days of the completion of the investigation. The departmental form has all of the components incorporated.

### §115.87 – Data Collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. Data is collected and reported on BJS Survey of Sexual Violence. Documentation confirmed that data is collected annually. Facility provided documentation of monthly incident based data for years 2013 and 2014, and the annual report by facility for 2013 and 2014.

### §115.88 – Data Review for Corrective Action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard and dictates compliance. The 2013 and 2014 Annual reports were reviewed. Comparisons were part of the data collection. The reports are available on the MDOC website.

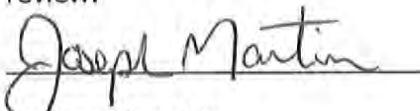
### §§115.89 – Data Storage, Publication, and Destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. A retention schedule was provided as well as a review made of the documentation available on the agencies website.

#### AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.



Auditor Signature

12-22-2015

Date

**PREA AUDIT REPORT**    ☐ Interim   ☒ Final  
**ADULT PRISONS & JAILS**

**Date of report:** August 12, 2015

<b>Auditor Information</b>			
<b>Auditor name:</b> Mark A. Mora			
<b>Address:</b> 500 Reformatory Hutchinson, Kansas 67501			
<b>Email:</b> mark.mora@doc.ks.gov			
<b>Telephone number:</b> 620-728-3374			
<b>Date of facility visit:</b> July 14-16, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Moberly Correctional Center			
<b>Facility physical address:</b> 1501 South Morley, Moberly, Missouri 65270			
<b>Facility mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Facility telephone number:</b> 660-263-3778			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
<b>Name of facility's Chief Executive Officer:</b> Warden Dean Minor			
<b>Number of staff assigned to the facility in the last 12 months:</b> 465			
<b>Designed facility capacity:</b> 1800			
<b>Current population of facility:</b> 1790			
<b>Facility security levels/inmate custody levels:</b> Medium/Minimum			
<b>Age range of the population:</b> 18-80 yoa			
<b>Name of PREA Compliance Manager:</b> Teresa Thornburg		<b>Title:</b> Deputy Warden	
<b>Email address:</b> teresa.thornburg@doc.mo.gov		<b>Telephone number:</b> 573-751-2389	
<b>Agency Information</b>			
<b>Name of agency:</b> Missouri Department of Corrections			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> State of Missouri			
<b>Physical address:</b> 2729 Plaza Drive Jefferson City, Missouri 65102			
<b>Mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Telephone number:</b> 573-751-2389			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> George Lombardi		<b>Title:</b> Director	
<b>Email address:</b> george.lombardi@doc.mo.gov		<b>Telephone number:</b> 573-751-2389	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Vevia Sturm		<b>Title:</b> Agency PREA Coordinator	
<b>Email address:</b> vevia.sturm@doc.mo.gov		<b>Telephone number:</b> 573-751-2389	



## **AUDIT FINDINGS**

### **NARRATIVE**

The PREA audit of the Moberly Correctional Center (MCC) was conducted on July 14-16, 2015 by Mark A. Mora certified auditor and the State of Kansas PREA Coordinator Elisabeth Copeland. The audit was conducted to determine compliance with the Prison Rape Elimination Act (PREA) standards.

The auditor provided MCC with the auditor notice which was posted throughout the facility 6 weeks prior to the on-site portion of the audit. The Pre-Audit Questionnaire and supporting documentation was provided to the auditor for review prior to the on-site portion of the audit. The materials received were compiled in a very organized manner. Prior to the on-site portion of the audit the auditor was provided communication with the MCC PREA Compliance Manager. Contact was made with Just Detention International (JDI) prior to the on-site visit. There was no information provided by JDI regarding MCC for this audit period. The auditor submitted a tentative schedule for the audit approximately one week prior to the on-site visit.

An entrance meeting was conducted on July 14, 2015 with the audit team and the MCC Administration that included; Warden Dean Minor, Deputy Warden Lisa Pogue, Assistant Warden Classification Dennis Allen, Corrections Supervisor (Major) Steven Simmons, Corrections Supervisor I Frank Gittemeier, Physical Plant Supervisor III Greg Brown, Functional Unit Managers Amanda Lake, Brent Pogue, Heather Townsend, Mark Trusty, Agency PREA Coordinator Vevia Sturm, Deputy Warden Offender Management and MCC PREA Coordinator Teresa Thornburg, and Case Manager II and Assistant MCC PREA Coordinator Adam Albach.

Following the entrance meeting a tour of the MCC facility was conducted which included all offender living units, offender services, the offender dining area, recreation areas, visiting room, industries areas, case management offices, medical and behavioral health areas, and shift supervisor areas. Informal interviews were conducted among staff and offenders during the facility tour.

Formal interviews were conducted with the MCC facility administration to include the Warden, PREA Compliance Manager, Case Managers, Investigators, and Security staff from each of three shifts. Staff were knowledgeable of MCC and agency policy in regards to their responsibilities in the event of a sexual abuse or sexual harassment incident.

Offenders interviewed were chosen randomly from rosters obtained by the auditor. Offenders related an awareness of the agency and facility zero tolerance policy and indicated PREA information is made available to them. Offenders also related they were aware of the avenues available to report an incident of sexual abuse or sexual harassment.

Investigation files were made available for review prior to and during the on-site portion of the audit. The Office of the Inspector General conducts sexual abuse investigations. It was determined investigations at MCC are conducted in a prompt, thorough and objective manner.

An exit meeting was held with MCC administrators on July 16, 2015. Clarification on the audit process was provided, questions were answered and recommendations were made by the auditor. MCC was determined to be in compliance with all applicable standards.

## **DESCRIPTION OF FACILITY CHARACTERISTICS**

The Moberly Correctional Center (MCC) is located at 1501 South Morley in Moberly, Missouri. MCC is an all-male medium/minimum security facility encompassing 38 buildings with the capacity of approximately 1800 offenders and was established in 1963. The age range of offenders is 18-80 years of age. MCC does not house youthful offenders. MCC has approximately 465 assigned staff.

MCC provides programming, classification and treatment to enhance individualized offender progression. MCC provides a number of work details, private industry employment and vocational programs to offenders. Offenders at MCC are provided with a number of recreational activities.

MCC maintains a camera monitoring system which enhances staff supervision of offenders.

## **SUMMARY OF AUDIT FINDINGS**

Number of standards exceeded: 0

Number of standards met: 43

Number of standards not met: 0

Number of standards not applicable: 0

### **Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Corrections (MDOC) maintains an agency policy D1-8.13 Offender Sexual Abuse and Harassment mandating a zero tolerance policy towards all forms of sexual abuse and sexual harassment. The policy outlines efforts toward prevention, detection and responding to all incidents of sexual abuse and sexual harassment. The policy also defines and dictates procedures for the same at each facility level.

The MDOC agency PREA Coordinator Vevia Sturm and PREA Site Coordinator Teresa Thornburg both concurred they have time and authority to develop and guide compliance at the agency and facility level.

### **Standard 115.12 Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Moberly Correctional Center (MCC) does not contract for confinement of inmates.

The agency contracts with 4 community confinement facilities through the Division of Probation and Parole.

The MDOC Division of Probation and Parole policy P4-6.1 dictates compliance with this standard.

The agency contract administrator generates the contracted agreement(s) and the division of probation and parole monitors compliance with the PREA Standards. The division of probation and parole conducts audits of each residential facility twice annually. In turn the division of probation and parole makes audit information pertaining to PREA available to the MDOC PREA Coordinator.

### **Standard 115.13 Supervision and monitoring**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 mandates each MDOC facility maintain a staffing plan to provide for adequate staffing levels. The policy further mandates an annual review with the agency PREA Coordinator.

Moberly Correctional Center's staffing plan is predicated on a maximum population of 1800 offenders. For this audit period, the average daily population for MCC was noted as 1758 offenders.

MCC deviations from staffing patterns are noted in shift chronological logs and custody staffing rosters.

MCC reported they have not deviated from the staffing plan and are able to do so by implementing mandatory overtime.

The auditor was provided with examples of custody rosters for review as part of the pre-audit documentation and during the on-site portion of the audit.

The auditor observed staffing patterns within living units and throughout the facility during the on-site facility tour phase of the audit process.

The MCC administrators interviewed were able to articulate all aspects of the staffing plan and measures taken to comply with agency and facility based policies.

#### **Standard 115.14 Youthful inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

MCC does not house youthful offenders.

Agency level compliance is as follows:

Agency policy D1-8.13 prohibits placement of youthful offenders in a living unit where there would be sight, sound, or physical contact with any adult offender(s). The policy addresses all the elements of Standard 115.14.

The State of Missouri regulation Chapter 217, Department of Corrections Section 217.345; prohibits placing youthful offenders with adult offenders and also requires physical separation and separate housing units.

Agency policy IS5-3.1 Offender Housing Assignments dictates; "youthful offenders will only be housed with other youthful offenders (standard operating procedures (SOP) will be developed to specify how such housing assignments will be made)."

Agency policy IS5-1.1 Diagnostic Center Reception and Orientation dictates procedures for the reception, transportation and housing of youthful offenders.

### Standard 115.15 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy IS20-1.3 Searches; dictates male offender pat searches are conducted by same gender staff members when multiple officers are present and cross-gender pat searches of female offenders only in exigent circumstances. In the event of a cross-gender pat search of a female offender, a cross-gender search form and report is generated to the PREA Site Coordinator for review to ensure exigent circumstances did in fact warrant the search. Cross-gender strip searches are allowed only in exigent circumstances. In such cases, the cross-gender strip search form and report will be generated and submitted to the PREA Site Coordinator. The PREA Site Coordinator documents the review in each case which accounts for whether or not the circumstances provided were exigent in nature. If exigent circumstances were not present, the cross-gender search review prompts a referral for investigation and an account of corrective action taken.

115.15 (b) is not applicable to this audit.

MCC reported no cross-gender strip or body cavity searches within this audit period.

Agency policy D1-8.13 mandates the announcing of opposite gender within the living units. The auditor viewed the chronological logs at various officer's stations within a number of living units noting the documentation of announcement of opposite gender staff within the living units. Due to the facility living units design, MCC makes opposite gender announcements at the beginning of each shift and when the gender of staff in the living unit changes from all male to female staff being assigned to the living unit. Interviews with offenders indicated they were made aware when opposite gender staff were working in the living units.

MCC provided the agency training curriculum and training video. Cross-gender pat searches and searches of transgender offenders are covered in the training materials. The materials were reviewed by the auditor and determined appropriate. Staff interviewed were able to articulate elements of the training they received in regards to offender searches.

During the on-site tour portion of the audit, offender shower areas in two different living units revealed offenders being in view of opposite gender staff while showering. The areas were reviewed with the MCC Warden and the auditor. Recommendations were made by the auditor and in turn the Warden directed immediate corrective action. The areas of concern were reviewed a second time by the MCC administration and the auditor during the on-site portion of the audit. The areas were then determined to be compliant with elements of this standard.

### Standard 115.16 Inmates with disabilities and inmates who are limited English proficient

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These**

**recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 outlines procedures for accommodating offenders with disabilities or who are limited English proficient.

MCC made available in their pre-audit documentation PREA brochures and acknowledgement forms in a number of different languages. The PREA brochure is also available in Braille for blind offenders.

Agency policy D5-5.1 Deaf and Hard of Hearing Offenders addresses the availability of services for hard of hearing offenders. The information on services is posted within the facility living units.

The National Institute of Correction's "Speaking Up" video and written transcript are used at MCC.

The auditor reviewed statewide contracts for language interpretive services which included sign language and services for the deaf and hard of hearing.

The auditor interviewed an offender identified as limited English proficient. The offender interviewed spoke primarily Spanish and was interviewed with the use of a staff interpreter. The offender related he was aware of ways to report an incident of sexual abuse or sexual harassment and made mention of posters which were also provided in Spanish throughout the facility.

The auditor observed PREA posters in English and in Spanish throughout the facility during the facility tour.

Although a number of staff interviewed were not clear on agency or facility policy regarding the use of offender interpreters, they were able to articulate what action would be taken when dealing with a limited –English proficient offender. It was recommended to the facility administration clarification on agency and facility policies in regards to the use of inmate interpreters be provided to staff.

**Standard 115.17 Hiring and promotion decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 and facility SOP D1-8.13; dictate compliance for this standard. Both policies prohibit the hiring or promotion of anyone who has engaged in sexual abuse with an offender in a prison, jail, community confinement, or lock up facility. The policies include juvenile facilities. The policies include all elements of the standard.

Agency policy D2-2.2 Background Investigations also addresses the procedure for background checks. MDOC utilizes the Missouri Uniform Law Enforcement System (MULES) and the National Criminal Information Center (NCIC) systems to conduct background checks. The policy also dictates background checks are conducted for promotion and other appointments.

MDOC also maintains agency policies; D2-2.8 Promotional Appointment; D2-2.10 Re-Employment Appointment, which contain elements of this standard in regards to background checks and contacting previous employers in regards to sexual abuse incidents.

Agency policy to include the employment application process includes contacting previous employers and dictates material omissions substantiate termination.

Agency policy D2-5.1 Maintenance of Employee Records provides; "Verification of information, other than public information, will be made with a written authorization from the employee."

The MDOC Department Procedure Manual D2-11.14 dictates background checks are conducted annually and according to the employee's birth month.

Staff interviewed were able to articulate agency and facility policy in regards to hiring and promotions.

MCC provided documentation of background checks for volunteers, contractors and other staff as supporting documentation for this standard. Background check information was viewed during the on-site portion of the audit.

For this audit period MCC reported 125 individuals newly hired, all of which had background checks completed.

#### **Standard 115.18 Upgrades to facilities and technologies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

There were no significant expansions or modifications to MCC during this audit period.

MCC in previous years has re-aligned living units to alleviate crowding in the segregation units.

Agency policy D4-4.8 Security Camera Operations addresses elements of this standard specifically element (b); noting the use of security cameras to enhance protecting offenders from sexual abuse.

MCC provided documentation which included a number of modifications to living units which included camera monitoring.

Administrative and Custody staff were able to identify and explain modifications to the facility to include specific surveillance camera placement throughout the facility during the on-site tour of the facility.

#### **Standard 115.21 Evidence protocol and forensic medical examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.8 Evidence Collection; outlines the agency's evidence protocol. MCC conducts their own administrative investigations. The auditor determined the policy and procedure adhere to the U.S. Department of Justice's Office on Violence Against Women publication, "A National Protocol for Sexual Assault Medical and Forensic Examinations, Adult/Adolescents."



Agency policy D1-8.13 also outlines protocol and procedure for forensic medical examinations subsequent to a sexual abuse incident. The policy also entails medical and behavioral health protocols for such events.

MCC offers all victims of sexual abuse access to forensic medical examinations. MCC utilizes primarily the University of Missouri Hospital Columbia, Missouri as their forensic medical examination resource. The forensic medical examinations are provided at no cost to the victim.

MCC maintains a memorandum of understanding with Safe Passage Domestic and Sexual Violence Crisis Center for community advocate services. The services include accompanying the victim through the forensic medical examination process.

MCC also provides a facility based advocacy service through their facility Chaplain. MCC provided the training curriculum and verification of training for the facility based advocate as supporting documentation for this standard.

MCC also provided documentation of community advocate services provided to MCC offender's as supporting documentation for this standard.

Staff interviewed were able to articulate the evidence protocols and forensic medical examination process. The staff interviewed or referenced included administrative, medical, behavioral health, and investigations.

#### **Standard 115.22 Policies to ensure referrals of allegations for investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The MDOC ensures an administrative or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Agency policy D1-8.13 and facility policy SOP D1-8.13 dictate procedures for such events. Inclusive are agency policies; D1-8.1 Investigation Unit Responsibilities and Actions; and D1-8.14 Administrative Inquiries.

Administrative Inquiry officers conduct administrative investigations. The Office of the Inspector General is responsible for criminal investigations.

The investigator interviewed was able to articulate all aspects of administrative and criminal investigations to include initial incident response protocol and procedure for forensic medical examinations.

Staff interviewed during the on-site tour and individual interviews were able to identify the staff or entity responsible for investigating incidents of sexual abuse and sexual harassment.

#### **Standard 115.31 Employee training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC provided their training curriculum and training video presentation as supporting documentation for this standard. The auditor reviewed the submitted material and determined all elements of Standard 115.32(a) were covered.

Policy also dictates the training will be tailored to the gender of offenders at the facility.

Training records were also submitted as supporting documentation to include employee verification of receiving and understanding the training received. All staff are inclusive in receiving training in regards to PREA. MDOC's definition of employee includes contractors and volunteers.

Staff interviewed during the facility tour and according to interview protocols were able to articulate elements of this standard.

### **Standard 115.32 Volunteer and contractor training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The agency and facility ensure all staff to include contractors and volunteers are trained in regards to the agency's zero tolerance sexual abuse and sexual harassment policies.

MCC retains documentation contractors and volunteers receive and understand the training they receive.

MCC provided supporting documentation to include training curriculum for volunteers and contractors. The documentation included records of all contractors and volunteers who received training. During this audit period MCC reported 68 volunteers and contractors received training.

The volunteer interviewed related elements of training and was able to articulate the responsibilities of a contractor or volunteer subsequent to a report of sexual abuse or sexual harassment.

### **Standard 115.33 Inmate education**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The MDOC utilizes the Speaking Up video, brochures and posters which are displayed throughout the facility. The posters and literature are formatted in a number of different languages.

MCC reported 1429 offenders received PREA information at intake during this audit period.

Offenders upon intake are housed in the Reception and Orientation Unit at MCC for approximately 30 days. During this time they are provided PREA information to include education on their right to be free from sexual abuse and sexual harassment or any type of retaliation for reporting such conduct. MCC provided supporting documentation noting offenders acknowledge the PREA information they receive.

PREA information is made available in formats to include offenders who are limited English proficient, deaf or hard of hearing and blind. The auditor reviewed PREA materials and concluded the materials contain the elements of Standard 115.33(a), (b).

The intake staff member interviewed related offenders normally receive orientation to include PREA information a day following their reception at MCC.

#### **Standard 115.34 Specialized training: Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The policy mandates specialized training for investigators. The investigators are trained by agency staff of the Inspector General's office.

The training contains 6 individual modules and incorporates a total of 36 hours of training. MCC provided the training curriculum as supporting documentation for this standard. The auditor reviewed the curriculum and determined the training complied with the elements of this standard.

MCC maintains 4 Administrative Inquiry Officers and 1 investigator for criminal investigations. For this audit period, MCC reported there were 32 investigators agency wide who conduct criminal investigations.

The investigator interviewed was able to articulate elements of the specialized training they received. The investigator was also able to explain the investigation process from initiation to completion or disposition. The investigator was also well versed on MCC operations, policies and procedures.

#### **Standard 115.35 Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 and facility SOP D1-8.13; dictates compliance with this standard.

MCC provided the specialized training for medical and behavioral health as supporting documentation for this standard. The auditor reviewed the curriculum and determined the training complied with elements of this standard.

The medical and behavioral staff interviewed were able to articulate elements of the specialized training and their role in the coordinated response to an incident of sexual abuse or sexual harassment.

#### **Standard 115.41 Screening for risk of victimization and abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.13; IS5-2.3 Offender Internal Classification, IS5-3.1 Offender Housing Assignments; dictate compliance with this standard.

All offenders are assessed for risk of victimization and abusiveness upon intake at MCC. Agency policies also dictate all offenders will be assessed upon transfer to another MDOC facility.

All offenders are assessed at MCC within the 72 hour time frame according to this standard. Interviewed staff indicated offenders are normally assessed the day following their reception at MCC. MCC provided supporting documentation of offender assessments within the 72 hour time frame.

The auditor reviewed the screening instrument utilized by the MDOC and determined the instrument appears to be an objective screening instrument based on the instrument containing the elements of Standard 115.41(d).

The screening instrument utilizes a number of different criteria considering each offender on a case-by-case basis. The criteria considered included past or prior incidents of sexual abuse known to the agency.

Agency policy IS5-2.3 mandates offenders will be reassessed within 30 days of intake at the facility. Policy also dictates a reassessment will occur subsequent to any additional relevant information received by the facility after the initial intake screening. MCC provided supporting documentation of offender 30 day reassessments.

Agency policy D1-8.13 mandates an offender will be reassessed due to a referral, request, an incident of sexual abuse or any additional information that may pertain to an offender's risk of sexual victimization or abusiveness.

Agency policy D1-8.13 denotes and offender will not be disciplined for refusing to answer or disclose complete information during the risk assessment.

Agency policy D1 -8.13 mandates the control and dissemination of information gleaned from the risk assessment instrument.

MCC provided the agency risk assessment tool and manual as supporting documentation for this standard. MCC also provided documentation which identified the total number of offenders assessed which included a breakdown of classification categories utilized by the MDOC.

The staff member interviewed was able to articulate how the risk screening instrument was utilized at MCC to include time frames and relevant dynamics pertinent to MCC.

#### **Standard 115.42 Use of screening information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 mandates the information from the risk screening instrument is used to determine housing, work, education and programming assignments for offenders and denotes assessments are done on an individualized basis.

Agency policy IS5-3.1 Offender Housing Assignments establishes the facility transgender committee is responsible for housing assignments for each transgender or intersex offender. The committee reviews each transgender and intersex offender's placement and management on a case-by-case basis every 6 months. The policy also provides each transgender or intersex offender's own views in regards to safety are given consideration. The policy also provides each transgender and intersex offender is given the opportunity to shower separately.

MCC provided a documented example of when a transgender offender requested and was provided the opportunity to shower separately.

MCC does not assign LGBTI offenders to dedicated living units.

Staff interviewed related how the transgender committee conducted reviews and proceedings. The auditor interpreted a commitment by the MCC administration to maintain appropriate supervision and communication with transgender offenders. There appeared to be open dialogue between the committee and the offenders. This was gleaned from offender interviews.

#### **Standard 115.43 Protective custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

Policy requires offenders assessed at high risk of victimization be placed in the least restrictive housing assignment possible. The policy also provides the assessment shall occur within 24 hours.

MCC provided a Segregated Housing for Protective Custody Directive noting elements of Standard 115.43 (a).

MCC provided supporting documentation which contained two examples of when offenders were placed in involuntary segregation subsequent to a report of suspected sexual abuse. The auditor interviewed these two offenders. Each offender related MCC's response to the reported incidents was appropriate in each case.

Staff interviewed indicated each allegation is considered on a case-by-case basis with the emphasis on providing for the least restrictive housing assignment for an offender victim.

MCC also provided Agency policy IS21-1.1 Temporary Administrative Segregation Confinement as supporting documentation for this standard.

#### **Standard 115.51 Inmate reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC provides a number of ways offenders can privately report an incident of sexual abuse or sexual harassment. Offenders may report in writing to staff, PREA hotline and by utilizing the agency grievance procedure.

MCC uses the Department of Public Safety as an avenue to report to an entity that is not part of the agency. The contact information is available in the offender PREA brochure.

MCC does not confine offenders for civil immigration purposes.

During the on-site tour of MCC and during interviews, offenders related they were comfortable or maintained no reservations with making a report of sexual abuse or sexual harassment to any staff member. There was no indication from offenders they perceived or had experienced any form of retaliation after making a report of sexual abuse or sexual harassment.

In regards to staff reports, staff can also privately report an incident of sexual abuse or sexual harassment on behalf of an offender by utilizing the Crime Tips hotline, Staff Tips hotline, consultation with an administrator or contacting the Department of Public Safety.

MCC provided as supporting documentation a memorandum of understanding (MOU) between the MDOC and the Department of Public Safety which outlines the responsibilities of each in the instance of a report of sexual abuse or sexual harassment.

### Standard 115.52 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.13 and D5-3.2 Offender Grievances; dictates compliance with this standard.

MCC maintains an administrative procedure to address offender grievances.

MCC reported there were no grievances alleging sexual abuse during this audit period.

MCC also provided there have been no request for extensions within this audit period, noting MCC had two grievances which did require an extension request however; the incidents were identified as sexual harassment incidents.

MCC maintains a grievance "Tracking Log" which was provided as supporting documentation for this standard.

Offender interviews provided no indication of concerns with the grievance process at MCC.

### Standard 115.53 Inmate access to outside confidential support services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC provides contact information to offenders for outside confidential victim advocacy services. Just Detention International and the Rape, Abuse and Incest National Network (RAINN) are utilized as providers. The contact information for these services is made readily available to offenders in posters throughout the facility and in PREA brochures. Offenders are advised phone calls are subject to being monitored.

Offender interviews indicated they were aware of the outside support services and how to contact them.

MCC also maintains a memorandum of understanding (MOU) with the Safe Passage Domestic and Sexual Violence Center for their community based advocacy services to offenders. MCC provided a documented example of an offender's use of this service. One offender interviewed related his experience in utilizing this service provider.

### Standard 115.54 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

MCC maintains a grievance procedure, PREA hotline, and accepts verbal and written reports from both family and the advocacy agency.

The MDOC maintains a website which publishes information on how to make a third party report for any incident of sexual abuse or sexual harassment. The website link is noted below:

<http://doc.mo.gov/od/PREA.php>

#### **Standard 115.61 Staff and agency reporting duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

Policy requires all staff to immediately report knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment. The same policy requires the same for any incident of retaliation involving a staff member. The policy is inclusive with medical and behavioral health staff and provides medical and behavioral health staff inform the offender at the initiation of services their duty to report and the limits of confidentiality.

The policy also mandates an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment.

Staff interviewed were able to articulate their duties and responsibilities as well as their obligation under policy and statute to report any incident of sexual abuse or sexual harassment.

MCC provided as supporting documentation for this standard; Missouri Revised Statutes Chapter 217, Department of Corrections Section 217.40 and Missouri Revised Statutes Chapter 630, and Department of Mental Health Section 630.005.

MCC provided agency policy IS11-32 Receiving Screening-Intake Section which dictates staff reporting duties and obligations in regards to juvenile offenders.

#### **Standard 115.62 Agency protection duties**



- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

All staff interviewed related they would take immediate action subsequent to a report of an offender being in substantial risk of imminent sexual abuse.

MCC provided an agency directive which outlines procedures for offenders segregated for protective custody issues to include offenders identified as high risk for victimization.

MCC also provided a number documented examples of offender involuntary segregation placements as supporting documentation for this standard.

#### **Standard 115.63 Reporting to other confinement facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC provided a number of examples of alleged sexual abuse reported to MCC and to other correctional facilities. The auditor reviewed the supporting documentation and determined MCC's response was within their agency policy and in compliance with this standard noting; MCC's response was within the 72 hour time frame for reports, the reports were documented, and investigations were initiated for the reports that were received by MCC.

Staff interviewed were able to articulate elements of agency policy in regards to reports of sexual abuse to other confinement facilities and reports received from other confinement facilities.

#### **Standard 115.64 Staff first responder duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC has an established coordinated response protocol which outlines duties and responsibilities of first responders to an incident of sexual abuse. The agency and facility protocol entails all elements of Standard 115.64 (a).

The coordinated response protocol applies to security and non-security staff. MCC provided as supporting documentation a number of examples of coordinated responses to incidents of sexual abuse where the first responder was security and/or non-security staff members.

Staff interviewed, including security, medical and behavioral health, volunteers and administrators were able to articulate their duties and responsibilities subsequent to a report of sexual abuse.

#### **Standard 115.65 Coordinated response**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The Coordinated Response to Offender Sexual Abuse is MCC's written institutional plan of coordinated response and actions to an allegation of offender sexual abuse. The coordinated response plan outlines specifically the actions and duties of staff to include; security staff, investigators, medical and behavioral health, and facility administrators.

The coordinated response plan includes an outline or event checklist denoting demographic information regarding the initial report and pertinent circumstances.

Staff interviewed were able to articulate elements of the coordinated response protocols.

#### **Standard 115.66 Preservation of ability to protect inmates from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

**recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D2-11.6 Labor Organizations; dictates compliance with this standard.

The policy mandates MCC will not enter into any collective bargaining agreement which would eliminate the ability to remove alleged staff sexual abusers from contact with offenders pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

MCC provided as supporting documentation the labor agreement between the MDOC and The Missouri Corrections Officers Association (MCOCA).

The effective date of the agreement was noted as 10/1/2014 to 9/30/2018. The auditor reviewed the agreement.

**Standard 115.67 Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The PREA Site Coordinator at MCC is responsible for monitoring for retaliation.

Multiple measures are utilized to ensure staff and offenders are protected from any form of retaliation in regards to a report of sexual abuse or sexual harassment.

Policy mandates monitoring will occur for a period of not less than 90 days. Policy dictates monitoring will continue past 90 days if the need exists. The policy denotes periodic status checks are completed every 30 days during the monitoring period. The policy denotes the facility will take appropriate measures to protect the offender or staff member from retaliation.

Policy dictates monitoring will conclude when it is determined the allegation is unfounded.

Staff interviewed were able to articulate agency policy in regards to monitoring for retaliation and what steps would be taken on behalf of a staff member or offender who either feared or was subjected to retaliation based on a report of sexual abuse or sexual harassment.

MCC provided a number of examples of retaliation monitoring as supporting documentation for this standard.

**Standard 115.68 Post-allegation protective custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The policy does not include what privileges, access to programs and work opportunities are available to offenders placed in involuntary segregation or if it is documented what access has been limited, the duration of any limitation, or the reason(s) they are limited.

MCC did provide an administrative memorandum which outlines elements of Standard 115.43 and 115.68. The memorandum; Segregated Housing for Protective Custody, dictates notifying offenders what privileges and/or programming will be restricted and for what duration.

MCC provided 2 documented cases of offender placement in involuntary segregation protective custody as supporting documentation.

The auditor reviewed investigation cases and in conjunction with results from staff interviews determined MCC in policy and practice, considers alternatives to involuntary segregation.

### **Standard 115.71 Criminal and administrative agency investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.13, D1-8.4 Administrative Inquiries, and D1-8.1 Investigation Unit Responsibilities and Actions; dictate compliance with this standard.

MCC investigators are under the jurisdiction of the Inspector General's Office. Investigators are required to maintain specialized training in sexual abuse investigations. MCC investigators conduct administrative and criminal investigations. MCC provided the specialized training curriculum and documentation investigators completed the specialized training as supporting documentation for this standard.

Investigators are trained to collect and preserve evidence, interviewing, report writing and continuing an investigation through to prosecution when warranted. MCC maintains a tracking system for all investigations.

MCC provided investigations for review prior to and during the on-site portion of the audit. The auditor determined the investigations were conducted in a prompt, thorough and objective manner.

The agency investigator interviewed was able to effectively articulate aspects of the administrative and criminal investigations process.

MCC reported 2 substantiated investigations which were referred for prosecution during this audit period.

### **Standard 115.72 Evidentiary standard for administrative investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.4 Administrative Inquiries and D1-8.13; dictate compliance with this standard.

MCC does not employ a standard higher than a preponderance of evidence as proof in determining whether allegations of sexual abuse or sexual harassment are substantiated.

### **Standard 115.73 Reporting to inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates; upon the conclusion of an investigation, the facility will inform the offender whether the allegation(s) has been determined substantiated, unsubstantiated, or unfounded.

115.73 (b) is not applicable to this audit.

The policy contains and addresses the remaining elements of this standard. The auditor reviewed supporting documentation provided prior to and during the on-site portion of the audit. The documentation reviewed included examples of notifications to offenders.

The investigator interviewed was able to articulate the method of reporting to offenders utilized at MCC.

### **Standard 115.76 Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.13 and D2-11.10 Staff Member Conduct; dictate compliance with this standard.

Policy D1-8.13 dictates staff are subject to disciplinary sanctions up to and including termination for violations of agency sexual abuse or sexual harassment policies. The policy includes termination as the presumptive disciplinary sanction for staff who has engaged in sexual abuse of an offender.

Policy D1-8.13 also dictates terminations for violations of agency sexual abuse or sexual harassment policies, or resignations by staff who would have been terminated if not for their resignation, shall be reported to law enforcement agencies, unless the activity was clearly not criminal, and to relevant licensing bodies.

Policy D2-11.10 addresses incidents of staff misconduct of a sexual nature and includes sexual abuse and sexual harassment of offenders.

MCC reported there have been no substantiated investigations of sexual abuse involving staff since August 2013.

### **Standard 115.77 Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies D1-8.13 and D2-13.1 Volunteers; dictate compliance with this standard.

Policy D1-8.13 dictates contractors or volunteers who engage in sexual abuse of an offender shall be prohibited from contact with offenders and shall be reported to law enforcement and relevant licensing bodies.

The policy further dictates the facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in cases of any other violations.

Policy D2-13.1 addresses conduct regarding volunteers and dictates any allegation of sexual abuse or sexual harassment will be referred for investigation.

MCC reported no incidents of sexual abuse or sexual harassment of offenders by contractors or volunteers since August 2013.

Staff interviewed related appropriate measures would be taken to ensure the safety of offenders in regards to allegations of sexual abuse or sexual harassment by any staff member.

### **Standard 115.78 Disciplinary sanctions for inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion**

**must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The policy dictates offenders are subject to disciplinary sanctions pursuant to a formal disciplinary process following an administrative finding the offender engaged in offender-on-offender sexual abuse. The sanctions shall be commensurate with the nature of and circumstances of the abuse committed, the offender's disciplinary history, and sanctions imposed for comparable offenses by other offenders with similar histories. If found guilty the offender shall be referred for appropriate treatment, to include therapy or counseling by behavioral health staff. Any offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent.

Agency policy IS19-1.1 MDOC Conduct and Rules Sanctions was provided by MCC as supporting documentation. The policy addresses consensual and non-consensual sexual activity regarding offenders.

### **Standard 115.81 Medical and mental health screenings; history of sexual abuse**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policies IS11-32 Receiving Intake Unit and D1-8.13; dictate compliance with this standard.

Each policy dictates if an offender discloses victimization or perpetration of sexual abuse whether in an institutional or community setting, staff shall offer a follow-up meeting with a medical or behavioral health practitioner within 14 days of the intake screening. It is noted as part the Adult Internal Risk Assessment screening whether a medical or behavioral health referral was accepted or declined and, if accepted, prompts staff to complete the behavioral health referral.

Any information related to sexual victimization or abusiveness that occurred in an institutional setting is limited to medical and behavioral health practitioners and other staff, as necessary, to inform treatment plans and security management decisions, to include housing, work, education, and program assignments. The policies include medical and behavioral health obtaining informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18.

MCC provided as supporting documentation for this standard, the MDOC PREA Risk Assessment Manual, behavioral health logs, risk assessment demographics, and examples of referrals to behavioral health staff.

For this audit period, MCC reported no notifications for offender sexual victimization that occurred outside the institutional setting.

Staff interviewed, which included a case manager, was able to articulate all the elements of the risk assessment process which was interpreted to be included with the orientation process at MCC.

Medical and behavioral health staff interviewed were able to articulate their role in the offender risk assessment and referral process.

### **Standard 115.82 Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-813 dictates compliance with this standard.

The policy dictates offenders shall receive timely unimpeded access to emergency medical and crisis intervention services. The scope of services will be determined medical and behavioral health practitioners according to professional judgment. Offender victims of sexual abuse while incarcerated shall be offered timely information about access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care where medically appropriate. Services will be provided to offender victims without financial cost regardless whether the offender victim cooperates with the investigation.

MCC utilizes CORIZON as their medical provider. MCC provided as supporting documentation the contractual agreement between MCC and CORIZON denoting CORIZON's obligation to provide medical and behavioral health services to MCC offenders in compliance with the PREA Standards. It is noted in the contractual agreement CORIZON will be responsible for and will arrange timely payment for all hospital and related health care expenses for offenders.

Staff interviewed were able to articulate the standard of care offenders receive subsequent to an incident of sexual abuse and otherwise. Medical and behavioral health staff interviewed contended the standard of care provided to offenders at MCC was equal to if not better than community level care.

#### **Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

MCC offers medical and behavioral health evaluations, and as appropriate, treatment to all offenders who have been sexual abuse victims in any prison, jail, lockup or juvenile facility. Follow-up services are provided and when necessary, referrals for continued care following the offender's transfer to, or placement in, other facilities, or release to the community. Treatment services are provided without financial cost and regardless of whether the offender names the abuser or cooperates with the investigation. An offender perpetrator of sexual abuse receives a behavioral health evaluation by a qualified behavioral health practitioner within 60 days of disclosure of such abuse.

115.83 (d), (e), do not apply as MCC is an all-male facility.

#### **Standard 115.86 Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)



- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The policy dictates MCC shall conduct a sexual abuse incident review (debriefing), at the conclusion of each sexual abuse investigation, including where the allegation(s) has not been substantiated, unless the allegation(s) was determined to be unfounded. The review is documented and forwarded to the PREA Coordinator, facility Chief Administrative Officer, and assistant division director. The reviews are ordinarily held within 30 days of a formal investigation. The review team includes facility management, line supervisors, investigators, and medical and behavioral health staff. Subsequent to the review, the facility shall implement the recommendations made by the review team or document the reasons for not doing so.

MCC provided an example of a sexual abuse incident review as supporting documentation for this standard.

Staff interviewed related the process and importance of conducting the incident reviews and were interpreted as involved and dedicated to the sexual safety of the facility.

#### **Standard 115.87 Data collection**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

Uniform data is collected by the Agency PREA Coordinator. The data is collected and reported in the BJS Survey of Sexual Victimization. The data is also available in the agency Corrections Information Network or (COIN) system. Documentation indicated the data is collected annually.

MCC provided the MDOC PREA Annual report by facility for years 2013 and 2014 as supporting documentation for this standard.

#### **Standard 115.88 Data review for corrective action**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The policy outlines the Agency PREA Coordinator's responsibility in collecting and aggregating data and preparing the agency annual report. Data was available on the agency's website and was reviewed by the auditor.

The data is collected and used to assess and improve the effectiveness of the agency's sexual abuse prevention, detection, and response efforts. The report identifies areas that may be problematic. The corrective actions taken are documented. The report entails all facilities within the MDOC. The report compares data from previous years to include corrective action measures taken by the agency and/or facility(s). The report is submitted and approved by the agency head, the Agency PREA Coordinator, and is provided on the agency's website. The agency redacts specific material from the report when publication would present a clear and specific threat to the safety and security of a facility within the agency. The agency indicates the nature of the material redacted.

### **Standard 115.89 Data storage, publication, and destruction**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Agency policy D1-8.13 dictates compliance with this standard.

The agency securely retains PREA data. The data is available on the agency website and is accessible to the public. Personal information is redacted.

### **AUDITOR CERTIFICATION**

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.



Auditor Signature

August 12, 2015

Date

# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
**PREA**  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

<b>Name of facility:</b>	Northeast Correctional Center		
<b>Physical address:</b>	13698 Airport Road Bowling Green, MO 63334		
<b>Date report submitted:</b>	August 5, 2015		
<b>Auditor Information</b>	<b>Joseph Z. Martin</b>		
<b>Address:</b>	374 New Bethel Church Road, Fredonia, KY 42411		
<b>Email:</b>	Joseph.martin@ky.gov		
<b>Telephone number:</b>	270 388-1048		
<b>Date of facility visit:</b>	May 12-14, 2015		
<b>Facility Information</b>			
<b>Facility mailing address: (if different from above)</b>			
<b>Telephone number:</b>	(573) 324-9975		
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	<input type="checkbox"/> Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b>	Chantay Godert		<b>Title:</b> PREA Compliance Manager
<b>Email address:</b> Chantay.Godert@doc.mo.gov	<b>Telephone number:</b>		(573) 324-9975
<b>Agency Information</b>			
<b>Name of agency:</b>	Missouri Department of Corrections		
<b>Governing authority or parent agency: (if applicable)</b>	Missouri Department of Corrections		
<b>Physical address:</b>	2729 Plaza Drive P.O. Box 236 Jefferson City, MO. 65102		
<b>Mailing address: (if different from above)</b>	Same as above		
<b>Telephone number:</b>	(573) 751-2389		

<b>Agency Chief Executive Officer:</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director
<b>Email address:</b>		<b>Telephone number:</b>	(573) 526-6607
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b>	Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b>	Vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	(573) 522-3325

## AUDIT FINDINGS

### NARRATIVE:

The site visit for the PREA Audit of the Northeast Correctional Center was conducted on May 12-14, 2015. The audit team consisted of the Audit Chair, Joe Martin KDOC/DOJ Certified PREA Auditor with two support staff consisting of Angelina Williams KDOC and Lindsay Stemle KDOC. During the Pre-Audit phase, the team reviewed the standards and completed much of the file review prior to the site visit. Follow-up documentation requirements was provided to the team on-site.

An entrance meeting was held at the beginning of our on-site visit with the following staff in attendance: Warden James Hurley, Deputy Warden Chantay Godert, Deputy Warden William Jones, Chief of Custody Tim Truelove and Assistant Warden Richard Griggs. I discussed with everyone the teams schedule of first wanting to tour the facility following the recommended tour guide from the PRC website and then interviewing the previously indicated staff and inmates for specialized and random interviews.

During the three day on-site portion of the audit, the team completed necessary file review follow-up including additional documentation review that was requested during the pre-audit phase. The team toured the institution and conducted formal staff and inmate interviews. The team interviewed 37 inmates consisting of 13 random (from each housing unit), 5 who reported sexual abuse, 8 disabled and limited English proficient, 5 who disclosed sexual victimization during risk screening and 6 LGBTI. In addition, the team interviewed 46 staff consisting of the warden, the compliance manager, 5 who perform the screening for victimization and abusiveness, 3 intake, 3 charged with monitoring retaliation, 3 who supervise segregated housing, 4 who have acted as first responders, 2 volunteerers/contractors, 2 investigative staff, 5 medical/mental health, 2 human resources, 3 intermediate to higher level supervisors, 2 that sit on the incident review team and 10 random (from each shift).

### DESCRIPTION OF FACILITY CHARACTERISTICS:

The Northeast Correctional Center is a Medium/Minimum custody facility that opened in March of 1998. It houses approximately 2,000 adult male inmates. NECC is a handicap accessible facility that houses inmates with special medical issues along with ones without special needs. NECC houses inmates ranging in age from 19 to 80 serving sentences from two years to life.



NECC offers programs that consist of Substance Abuse and Treatment, Anger Management, Parenting and Cognitive Thinking. It also offers vocational education programs that consists of Professional Gardening, Computer Repair, Automotive Technology and Truck Driving is being added soon.

### **SUMMARY OF AUDIT FINDINGS:**

The team found that staff and inmates had good general knowledge of PREA. The team was impressed with Warden Hurley as he demonstrated care and thorough knowledge of the facility and took great pride and ownership of his staff and the PREA efforts of the facility.

During the on-site audit, standards 115.78 and 115.81 were found to be in non-compliance. A 90-day Corrective Action was taken and since then the facility has submitted documentation that has brought these standards into compliance. For standard 115.78 NECC held training for all appropriate staff detailing that before adjustment hearings are held for inmate on inmate sexual perpetrators that mental health input is received before adjudication for consideration and that mental health referrals are made for those convicted of perpetration. For 115.81 documentation was submitted to show that referrals are made and documented showing inmates who disclose prior sexual victimization are offered medical and/or mental health services. NECC is now in full compliance with all PREA standards.

Each standard below will have comments/recommendations and justifications to why compliance or non-compliance was determined.

Number of standards exceeded:	1
Number of standards met:	41
Number of standards not met:	0
Not Applicable:	1

#### **§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 8.13 outlines the departments process in preventing, detecting and responding to inmate sexual abuse and sexual harassment. MDOC has an agency-wide PREA Coordinator. In addition, each facility has a designated PREA Compliance Manager.

### **§115.12 - Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

MDOC obligates contracted entities to adopt and comply with the PREA Standards. Sample documentation of contracts verified and instrument used for on-site visits demonstrates contracted facilities are visited to check compliance.

### **§115.13 – Supervision and Monitoring**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

NECC provided documentation that all components of section (a) is considered in its staffing plan. NECC found earlier this year that they were not meeting the required minimum number of security staff to operate it's dayshift and evening shift. This error was corrected immediately and the Warden assured that all appropriate supervisory staff have been educated and are quite aware of the minimum numbers that security shifts have to operate with and mandatory posts have been determined.

NECC documented it's reasoning for deviating from it's established staffing plan even though the minimum numbers were incorrect. The 2014 Annual Report was reviewed.

Policy D1 8.13 directs for supervisory unannounced rounds and prohibits staff from alerting other staff of the rounds. Interviews of supervisory staff corroborated this practice along with documentation provided.

### **§115.14 – Youthful Inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

This standard is Non-Applicable for NECC as it does not house Youthful Offenders.



### **§115.15 – Limits to Cross-Gender Viewing and Searches**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy IS20-1.3 outlines standard. NECC reported no instances of cross-gender strip or visual body cavity searches. Policy D1-8.13 directs that inmates be able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing the inmate's buttocks or genitalia. NECC provided documentation of this practice and staff and inmate interviews corroborated. In addition, documentation was provided that all security staff have been trained on how to conduct cross-gender pat-down searches and searches of transgender and intersex inmates. Staff interviews corroborated training was completed.

### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1. 8.13 outlines standard. NECC has contacts with Interpreter Services if the need arises. The facility has PREA posters along with victim advocate information posted throughout the facility. They also have braille and Spanish versions available.

### **§115.17 – Hiring and Promotion Decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

MDOC does not hire or promote anyone who fails to meet stipulations outlined in this standard. The state application incorporates direct language from standard. Policy D2 2.2 and a Directive from the agencies Human Resources directs practice of hiring and promoting with stipulations of this standard. The Employee Handbooks directs a continuing affirmative for employees to report this type of misconduct. In addition, criminal background checks are done for all staff annually. I spot checked on-site to verify and H&R staff interviews corroborated.

### **§115.18 – Upgrades to Facilities and Technology**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D4. 4-8 incorporates direct language from standard. NECC is in the process of modifying some of its inmate housing units. The modifications will enhance the facilities ability to protect and monitor inmates from sexual abuse and/or sexual harassment.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency utilizes investigators from the Inspector General's office which is part of the MDOC. Policy D1-8.8 describes protocol. NECC utilizes the local hospital in their plan if a forensic exam was to be needed for inmate sexual abuse. NECC reported 3 instances of this occurrence within the last 12 months. NECC provided victim advocacy services from a local community center and trained staff.

Documentation review showed use of victim advocacy throughout investigations including exams. NECC posts advocacy information throughout the facility. Inmate interviews corroborated education is given and is readily available.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13 and D1-8.1 directs for all allegations of sexual abuse and sexual harassment to be investigated. Documentation review proved investigations are conducted appropriately and thoroughly. Staff interviews corroborated understanding of their responsibilities for referrals for criminal behaviors.



### **§115.31 – Employee Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines employee training and PREA. Lesson Plans and curriculum used covers all aspects of section (1) –(10) used in basic training and refresher training. MDOC has different lesson plans for staff working at male vs female facilities. MDOC requires acknowledgment forms from staff who complete this training and NECC keeps this documentation as it was reviewed.

### **§115.32– Volunteer and Contractor Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1 -8.13 outlines this standard. NECC reported 56 volunteers/contractors had received training. NECC maintains documentation of participation and acknowledgment forms are kept. Volunteer interviews corroborated they had received training and it is continued annually.

### **§115.33 – Inmate Education**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

NECC educates newly arrived inmates of the agencies zero-tolerance regarding sexual abuse and sexual harassment and to report such incidents. NECC shows videos to new arrivals which covers all components of this standard. NECC reported 1587 inmates had been educated within the last 12 months. NECC provides this education to inmates who are handicapped or disabled. Documentation and acknowledgment forms are maintained of this training.

### **§115.34 – Specialized Training: Investigations**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

NECC exceeds this standard as their administrative and criminal investigators have received specialized training on how to conduct sexual abuse and/or sexual harassment investigations in confinement settings. The training curriculum and lesson plans used exceed the requirements outlined in this standard. Interviews with investigators showed great knowledge and experience possessed.

### **§115.35 – Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 outlines requirements of this standard. NECC was found to have all of their medical and mental health staff properly trained. NECC keeps documentation of this training and staff interviews corroborated they had received it.

### **§115.41 – Screening for Risk of Victimization and Abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 pages 9 and 10 address screening upon admission to facilities or transfers between facilities. Staff responsible for Risk Screening had good knowledge of procedure in conducting screenings. Sample documentation provided showed good practice and compliance.

### **§115.42 – Use of Screening Information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)



☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13, IS5 2.13 Classification, IS5 3.1 Offender Housing Assignments and Committee Review Team directs standard. Sample documentation to ensure proper placement, programming and assessment needs was provided. Inmates interviewed all had good knowledge of housing and program decisions based on the screening information. The facility has a Transgender/Intersex committee that reviews each for safety and security.

### **§115.43 – Protective Custody**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and directs standard. NECC reported no inmates that were reported victims of sexual abuse were housed in involuntary segregated housing. Sample documentation was provided that showed alternate housing was provided.

### **§115.51 – Inmate Reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13 and D1-8.9 are written and directs the standard. Staff and inmates interviewed had a good knowledge and understanding of how and different ways to report allegations of Sexual Abuse and/or Sexual Harassment. Documentation provided of brochures, posters and memos. The tour of the facility revealed posters and other PREA related information was posted throughout the facility.

### **§115.52 – Exhaustion of Administrative Remedies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

SOP D5-3.2 Offender Grievances and D1-8.13 Offender sexual abuse and sexual harassment policies are in place. Documentation was provided of grievance logs and offender grievances. Staff interviews revealed good knowledge of the grievance process involving PREA allegations. The inmates interviewed also knew the grievance process regarding PREA allegations.

#### **§115.53 – Inmate Access to Outside Confidential Support Services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 section K outlines this standard. NECC has a Memorandum of Understanding with a local community Victim Advocate Center. NECC also had posted throughout the facility the information needed to correspond with JDI and RAINN. Staff and Inmates had a good general knowledge of what Victim Advocates is for and how to contact them.

#### **§115.54 – Third-Party Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency provides information concerning third-party reporting on it's website. The inmates interviewed had a good general knowledge of third-party reporting as well as the staff interviewed.

#### **§115.61 – Staff and Agency Reporting Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies D1-8.13 and ISII-32 direct this standard. Sample documentation was provided which showed compliance. Staff interviewed were knowledgeable of this standard to include the responsibility to report, to whom they would report and the confidentiality thereof.



### **§115.62 – Agency Protection Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and directs. The sample documentation provided showed immediate action. Staff interviews revealed they had a good general knowledge that immediate action was to be taken and that they would protect the inmate with also making proper notifications to other staff.

### **§115.63 – Reporting to Other Confinement Facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. A sampling of documentation provided showed practice with all components being met. In addition, staff interviews showed appropriate staff had good general knowledge of the requirements of this standard.

### **§115.64 – Staff First Responder Duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs standard. Annual training for all staff incorporates duties as all staff can be first responders. Documentation was provided. Staff interviews showed all had a good general knowledge of their responsibilities in the role as a first responder and all knew basic information of separating and protecting potential evidence.

### **§115.65 – Coordinated Response**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

NECC has an individualized coordinated response. This standard was discussed with appropriate staff and they seemed to have a good general knowledge of it's usefulness and applicability.

#### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

An agreement is in place that is in compliance with the requirements of this standard. The agency understands this standard and is in compliance.

#### **§115.67 – Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and protects all inmates and staff who report sexual abuse and sexual harassment or those who cooperate with the investigations. Documentation was provided which showed compliance for monitoring with staff and inmates and the different subjects to monitor for each. NECC uses facility Unit Managers for monitoring under the supervision of Compliance Manager Deputy Warden Godert.

#### **§115.68 – Post-Allegation Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 incorporates language from this standard. NECC reported that they had no inmates placed in involuntary segregation. Staff seemed to have good knowledge of this standard as they always consider alternate housing before placing alleged victims in segregation.



### **§115.71 – Criminal and Administrative Agency Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.1 is written that outlines departmental investigations. Documentation provided was good and showed thorough investigations are being completed for all allegations of sexual abuse and/or sexual harassment. Investigator interviews were very good and showed that the facility has knowledgeable experienced investigators.

### **§115.72 – Evidentiary Standard for Administrative Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.1 is written and outlines preponderance of evidence required. Documentation of investigations provided showed investigations and conclusions meet compliance. Investigator interviews showed they were very knowledgeable of the investigative process and of making conclusions from the evidence obtained.

### **§115.73 – Reporting to Inmate**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- x Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and directs reporting requirements. Sample documentation provided was good and staff interviews corroborated this standard and practice is institutionalized.

### **§115.76 – Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and directs disciplinary sanctions for staff. Sample investigations were provided to show compliance with the standard. Investigations provided were staff resignations prior to being terminated. However, investigations continued regardless of resignations.

#### **§115.77 – Corrective action for contractors and volunteers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is written and directs this standard. There were no instances at NECC of this occurring however staff interviews, including the warden, showed a good understanding of restricting contact if the need arises.

#### **§115.78 – Disciplinary sanctions for inmates**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 is in place along with a directive from agency leadership directing this standard. NECC provided documentation that training has been held for all appropriate staff detailing that mental health input must be received before inmate on inmate perpetrators are adjudicated and that referrals are made for those convicted.

#### **§115.81 – Medical and mental health screenings; history of sexual abuse**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. NECC provided documentation showing the practice of offering inmates who disclose prior sexual victimization follow-up services from medical and/or mental health practitioners has been institutionalized.



### **§115.82 – Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. Documentation was provided of instances where inmate victims of sexual abuse received medical and mental health services. The team recommends that a log is kept at NECC with specific information pertaining to each incident for easy reference and record keeping.

### **§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. Sample documentation was provided through investigations as well as medical and mental health documentation. The team recommends a log with specific information be kept as mentioned in the above standard.

The facility does not house female inmates making sections (d) and (e) inapplicable.

### **§115.86 – Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs for Incident Reviews to be completed for each allegation of sexual abuse that was found to be substantiated or unsubstantiated. Documentation reviews showed that these reviews may not be occurring regularly within 30 days after the investigation. The team finds this standard in compliance with recommending that staff be reminded that reviews (debriefings) are to normally occur within 30 days of completion of the investigation.

### §115.87 – Data Collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard and entails clear definitions of sexual abuse and sexual harassment between staff and offender and offender on offender. Documentation review showed all allegations are logged and investigated properly.

### §115.88 – Data Review for Corrective Action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy D1-8.13 directs this standard. The 2013 and 2014 annual reports were reviewed and comparisons were noted as data collection. These reports are available on the agencies website.

### §§115.89 – Data Storage, Publication, and Destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

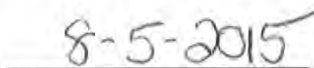
Policy D1-8.13 directs this standard. A retention schedule was provided as well as a review made of the documentation available on the agencies website.

#### AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.



Auditor Signature



Date



# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

<b>Name of facility:</b>		Potosi Correctional Center	
<b>Physical address:</b>		11593 State Highway O Mineral Point, MO. 63660	
<b>Date report submitted:</b>		April 22, 2015	
<b>Auditor Information</b>		<b>Joseph Z. Martin</b>	
<b>Address:</b>		374 New Bethel Church Road, Fredonia, KY 42411	
<b>Email:</b>		Joseph.martin@ky.gov	
<b>Telephone number:</b>		270 388-1048	
<b>Date of facility visit:</b>		March 24 – 26, 2015	
<b>Facility Information</b>			
<b>Facility mailing address:</b> <i>(if different from above)</i>			
<b>Telephone number:</b>		(573) 438-6000	
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	<input type="checkbox"/> Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b>		Cindy Griffith	<b>Title:</b> PREA Compliance Manager
<b>Email address:</b> cindy.griffith@doc.mo.gov		<b>Telephone number:</b>	(573) 438-6000
<b>Agency Information</b>			
<b>Name of agency:</b>		Missouri Department of Corrections	
<b>Governing authority or parent agency:</b> <i>(if applicable)</i>		Missouri Department of Corrections	
<b>Physical address:</b>		2729 Plaza Drive P.O. Box 236 Jefferson City, MO. 65102	
<b>Mailing address:</b> <i>(if different from above)</i>		Same as above	
<b>Telephone number:</b>		(573) 751-2389	

<b>Agency Chief Executive Officer:</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director
<b>Email address:</b>		<b>Telephone number:</b>	(573) 526-6607
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b>	Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b>	Vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	(573) 522-3325

## AUDIT FINDINGS

### NARRATIVE:

The site visit for the PREA Audit of the Potosi Correctional Center was conducted on March 24 – 26, 2015. The audit team consisted of the Audit Chair, Joe Martin KDOC/DOJ Certified PREA Auditor with two support staff consisting of Scott Jordan, KDOC/DOJ Certified PREA Auditor and Abby McIntire, KDOC/DOJ Certified PREA Auditor. During the Pre-Audit phase, the team reviewed the standards and completed much of the file review prior to the site visit.

During the three day on-site portion of the audit, the team completed any necessary file review follow-up, toured the institution and conducted formal staff and inmate interviews. The team interviewed 26 inmates, including 11 random inmates (with representation from each of the housing units), 6 inmates who disclosed sexual victimization during risk screening, 4 inmates identified as gay, bi-sexual or transgender, 3 inmates who were disabled or limited English proficient and 2 inmates who had reported sexual abuse. In addition, the team interviewed 41 staff, including 26 specialized staff, 2 volunteers and 13 randomly selected officers (representing all shifts and various posts). The interviews covered training, first responder duties, how to report, whom to report, filing reports, conducting interviews, evidence collection, medical and mental health responses, monitoring retaliation and reviewing substantiated and unsubstantiated incidents of sexual abuse.

An entrance meeting was held at the beginning of our visit with the following persons in attendance: PREA Coordinator Vevia Sturm, Warden Cindy Griffith, Deputy Warden Jamie Crump, Chief of Custody Greg Dunn and Assistant Warden Teri Lawson. The Audit team discussed our duties and what areas of the facility we wanted to tour along with explaining the interview process of staff and inmates.

### DESCRIPTION OF FACILITY CHARACTERISTICS:

Potosi Correctional Center is an 852 bed Medium/Maximum custody institution located approximately 75 miles southwest of St. Louis. The facility opened in 1989 and is situated on 140 acres within Washington County. The primary structure consists of seven interconnected buildings with approximately 350,000 square feet. Six housing units are located with the main security section which is divided by zones.

Housing units 1 through 4 are located in Zone 2 and housing units 5 and 6 are located in Zone 1. Outside the main security fencing is a minimum security unit which houses 90 minimum security offenders utilizing work release.

### **SUMMARY OF AUDIT FINDINGS:**

An exit interview was held at the end of our visit to brief the Executive staff of the team's findings.

The team found that staff and inmates had a good general awareness of PREA and the rights encompassed. Staff were aware of reporting duties, protecting inmates of alleged sexual abuse and/or sexual harassment and thoroughly investigating all claims. Inmates were found to be educated of their rights to be free from sexual abuse and/or sexual harassment and knew the facilities reporting methods along with victim advocate services that were available.

During the tour the team found that housing unit 7 had inadequate privacy partitions for inmates. Upon questioning, the Warden explained that female staff were not allowed in the bathroom except in exigent circumstances. The Warden and I discussed and I explained if the security need was present that privacy partitions could be installed in the bathroom so that female staff could conduct security rounds through the bathroom. The Warden agreed that the option would be beneficial and privacy partitions were placed beside the urinals and a privacy curtain was placed at the entrance to the shower area. This allowed obscurity of the inmates genitalia and buttocks while still allowing security observation of the restroom area by male and female staff. This topic was again discussed at the exit interview and the Warden seemed to have a good understanding of their options regarding the bathroom area of housing unit 7.

All standards were found to be in compliance. Each standard below will have comments/recommendations from the team member assigned to the standard.

Number of standards exceeded: 1

Number of standards met: 41

Number of standards not met: 0

Not Applicable: 1

#### **§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Missouri Department of Corrections has a policy mandating zero tolerance towards all forms of sexual abuse and sexual harassment. (D1 8.13). They also have a PREA Coordinator for the department with each facility having a PREA Compliance Manager.

### **§115.12 - Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency does contract for the confinement of its inmates with other entities. Documentation provided of contracts showed the responsible of the entity to abide by PREA Standards. In addition, the Department has a tool in place to monitor compliance of contractor.

### **§115.13 – Supervision and Monitoring**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The facility has a staffing plan with components considered in section (a). The facility had one deviation from their staffing plan and they supplied documentation and justification as to why.

Agency policy directs unannounced rounds by supervisors and prohibits staff from alerting other staff these rounds are occurring. The facility supplied good documentation of practice and staff interviews confirmed.

### **§115.14 – Youthful Inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

This standard is non-applicable as the facility does not house youthful offenders.

### **§115.15 – Limits to Cross-Gender Viewing and Searches**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Potosi does not conduct cross-gender strip or cross-gender body cavity searches of inmates unless exigent circumstances exist and then only by medical practitioners. Policy IS20-1.3 outlines the agencies search procedures.

Agency policy D1 -8.13 outlines inmates being able to shower, perform bodily functions and change clothing without non-medical staff of the opposite gender viewing their genitalia and buttocks except in exigent circumstances. In addition, opposite gender announcement requirements are outlined in the policy. The facility provided documentation of this practice and showed in their Facility Post Orders that the Control Center officers are responsible for ensuring the cross-gender announcements are made.

Housing Unit 7, as mentioned in the narrative, had inadequate coverage in the restroom area of providing obscenity to the inmates genitalia and buttocks area. Female staff were restricted to enter the area unless exigent circumstances existed. In discussion with facility leadership it was discussed that they had an option of placing partial privacy partitions in the shower area and around the urinals that would allow for female staff to make security rounds through the area. The facility placed the partitions in the restroom allowing them to have the option if chosen.

### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.13 outlines standard. The facility uses brochures and videos in educating newly arrived inmates. The facility also has PREA education modules that they program on the institution's television channel along with posters and victim advocate information being posted throughout the facility.

The facility has a plan if needed to bring translational services to the facility in the need they receive an inmate who is limited English proficient.

### **§115.17 – Hiring and Promotion Decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D2-2.2 outlines standard. Additional directive from Human Resources restricts the hiring or promoting of someone from a substantiated sexual abuse incident. The agency performs criminal background checks before hiring anyone and checks for components of section (a).

Facility provided good documentation of checks completed for all staff including contractors. Staff interviews of the facilities Human Resources Office showed general knowledge of standard and confirmed checks were being completed.

### **§115.18 – Upgrades to Facilities and Technology**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The facility had expanded its camera coverage in the canteen area therefore enhancing the safety of inmates from being sexually abused.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.8 and D1 8.13 outlines standard and states investigators from the Inspectors General's office is responsible for conducting sexual abuse investigations. This office is part of the department of corrections. The facility incorporates a protocol for obtaining usable physical evidence in response readiness for all incidents of sexual abuse.

SANE's are provided to inmate victims of sexual abuse without cost. Local hospitals are used to accomplish this exam when needed. The facility uses a community victim advocate service. The Southeast Missouri Family Violence advocate service is used and a MOU details the responsibility of each party involved. I contacted the center and spoke with the Sexual Assault Advisor. She was complimentary of the prison and knew great detail of the responsibility of



being a victim advocate. In addition, the facility has posted throughout the facility the contact information for JDI and RAINN.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.1 and D1 – 8.13 directs all allegations of sexual abuse and sexual harassment are investigated. The agencies website had a link to their PREA policies outlining criminal investigations.

### **§115.31 – Employee Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.13 details standard. The agencies lesson plan incorporates all sections outlined in section (a). In addition, a lesson plan is in place oriented towards instiutions that house female offenders. The facility keeps documentation of each employee receiving this training with acknowledgment forms.

### **§115.32– Volunteer and Contractor Training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 -8.13 directs training for volunteers and contrators. Documentation provided adequate. Training is conducted annually.

### **§115.33 – Inmate Education**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi educates inmates during the intake process by providing brochures and video programming. This consists of inmate's right to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting.

Agency policy D1 – 8.13 requires inmates transferred from one facility to another to be educated. Potosi uses the NIC video, posters and has available braille and interpreters when needed. Key Information is continuously available as they have posters throughout the facility and provide continuing education through their inmate television channel. Acknowledgment forms are maintained which are signed by the receiving inmates.

### **§115.34 – Specialized Training: Investigations**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.13 directs for criminal investigators to receive specialized training. The lesson plans provided were very good and exceeded the expectations of this standard. In addition, the facilities criminal investigator and their Administrative Investigator both had received specialized investigator training.

### **§115.35 – Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.13 directs training of medical and mental health staff. Lesson plan incorporates components of section (a). medical staff at Potosi do not conduct forensic examinations but inmates are taken to local hospitals when the exams are warranted. Documentation was good and confirmed training.

### **§115.41 – Screening for Risk of Victimization and Abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency policies (SOP 5-2.3 & D1-8.13) clearly outline the requirements of this standard. The Policy requires that the offender be assessed during intake within 72 hours upon arrival and upon transfer to a different facility. PCC has completed assessments on all existing inmates and has a system and practice in place to ensure compliance.

### **§115.42 – Use of Screening Information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

PCC operates and documents housing assignments using a system of Alpha and Sigma to identify inmates in regards to housing and work assignments. IS/SOP 5-3.1 requires a committee for Transgender/Intersex inmates and reviews every 6 months in regards to placement and programming, inmates own views, showering guidelines etc.

Inmate and Staff interviews indicated clearly that at no time were inmates to be fully unclothed in plain view of staff or even other inmates.

### **§115.43 – Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

PCC provided documentation that they had not placed any inmates in involuntary segregation for risk of being a victim. D1-8.13 outlines the directives of segregation for protection and investigation.

### **§115.51 – Inmate Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

During site visit and interviews, it is very clear the inmates and staff have been educated and continue to receive information on reporting. They were also very educated on where to get the information.

### **§115.52 – Exhaustion of Administrative Remedies**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency policy (D5-3.2) outlines the process of grievances that allege sexual abuse. PCC had documentation on such grievances over the last 12 months and they were handled according to the policy. It outlines the assistance inmates may receive in the informal stage. The assistance cannot interfere with safety and security of the institution. Policy dictates that the emergency grievances are responded to within the time frame. Policy also allows for disciplinary action against an inmate who files a false claim.

### **§115.53 – Inmate Access to Outside Confidential Support Services**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

According to policy(D1-8.13) and practice at the institution, and the MOU, inmates are provided access to a qualified victim advocate. Inmates knew this during interviews. Posters were in place and it was clear during interviews that they had been in place for quite some time. Addresses were posted along with confidentiality statements.

### **§115.54 – Third-Party Reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Agency receives reports from third parties from the toll free hotline and address that is posted on the website.

### **§115.61 – Staff and Agency Reporting Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Agency policy (D1-8.13) addresses this standard. All staff interviewed were very aware of the reporting obligations and also the confidentiality of reporting. All staff stated that they would in fact report if the need to do so. The institutional Coordinated Response is in place and by policy.

### **§115.62 – Agency Protection Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency Policy and Practice are very clear in protection of inmates that are at risk. Staff interviews indicated a clear understanding and willingness to make sure this protection happens.

### **§115.63 – Reporting to Other Confinement Facilities**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for

☐ Does Not Meet Standard (requires corrective action)

The Agency Policy (D1-8.13) provides a clear reporting procedure. The facility provided documentation that shows this reporting protocol work.

### **§115.64 – Staff First Responder Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Agency Policy (D1-8.13) and Post Orders include and address all areas of first responders. During interviews, staff indicated by answers of questions that they had a clear understanding of protecting victims, separation, evidence collection and what other action is required.

### **§115.65 – Coordinated Response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Agency and Facility have a in place a facility specific Coordinated Response. A copy of this response was included for review.

### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Missouri Department of Corrections documents and makes it clear in their labor agreement with the Missouri Correctional Officers Association that they have the right to hire, assign, reassign, transfer, promote and to determine hours of work and shifts, also to assign overtime.

### **§115.67 – Agency protection against retaliation**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency Policy (D1-8.13) clearly outlines that retaliation against any party involved in a complaint is strictly prohibited. It also states that the shall designate a staff member or department of the facility to monitor retaliation. The Unit Manager is responsible for monitoring inmate retaliation and the PREA site coordinator is responsible for monitoring staff for retaliation. PCC reports that they have had no instances of retaliation during this

reporting period. During the interview process, the staff members displayed their responsibility and knowledge.

### **§115.68 – Post-Allegation Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

PCC has not placed any inmates in Segregation for protective custody during this reporting period. The provided documentation indicates that they have met both standard 115.43 and 115.68 which both address the PC issue have been followed and meet compliance.

### **§115.71 – Criminal and Administrative Agency Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi did not have any substantiated allegations that were referred for prosecution. Policy D1 - 8.13 Section III clearly outlines how the facility shall conduct criminal and administrative investigations.

### **§115.72 – Evidentiary Standard for Administrative Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

It was evident in the investigations provided as documentation that the agency does impose the standard requiring a preponderance of evidence when determining whether allegations reported and investigated of sexual abuse or sexual harassment are substantiated.

### **§115.73 – Reporting to Inmate**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi provided examples of letters that are sent to the inmate to inform them whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded.

During an interview with an inmate he provided a copy of a letter sent to him by the agency advising him of the outcome of his investigation. The letter was more than sufficient and thoroughly explained the outcome.

### **§115.76 – Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi has not had any staff in the facility that have violated the agency sexual abuse or sexual harassment policies, nor have they had any staff that have been terminated or resigned prior to termination for violating agency sexual abuse or sexual harassment policies.

Agency policy D1 – 8.13 does state that staff members shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment procedures.

### **§115.77 – Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi has not had any contractors or volunteers that have engaged in sexual abuse. Agency policy D1 – 8.13 outlines the corrective action for contractors and volunteers.



### **§115.78 – Disciplinary sanctions for inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi reported that they have not had any administrative findings of inmate-on-inmate sexual abuse. They also reported they have had no criminal findings of guilt for inmate-on-inmate sexual abuse.

Documentation was provided to show the policy on inmate disciplinary sanctions.

### **§115.81 – Medical and mental health screenings; history of sexual abuse**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Inmates who have disclosed any prior sexual victimization during the screening are all offered a follow-up meeting with a medical or mental health practitioner within 14 days of the screening.

Mental Health electronically keeps records showing the inmate was offered a follow-up meeting within 14 days. Also note that during the inmate interviews the inmates stated that they were asked if they would like to have a follow-up meeting with a medical or mental health practitioner.

### **§115.82 – Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Documentation was provided showing that the medical contract clearly states that Corizon will comply with the PREA Act of 2012, medical and behavioral health care will be provided immediately upon report or discovery, to victims of sexual misconduct.

### **§115.83 – Ongoing medical and mental health care for sexual abuse**

## **victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1 – 8.13 states that upon receiving a report of a sustained case of offender sexual abuse the PREA coordinator will submit a referral and screening note – health services form to ensure the perpetrators will be assessed by qualified mental professional within 60 days of learning such abuse.

115.83 (d) Not applicable due to facility being an all male facility.

## **§115.86 – Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Potosi provided documentation on three investigations that demonstrated the facilities investigations are being investigated and documented correctly and are detailed.

## **§115.87 – Data Collection**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency is accurately keeping data through the Corrections Information Network. Documentation of the reports were provided agency-wide.

115.87 (e) does is not applicable, the agency does not contract for the confinement of its inmates.

## **§115.88 – Data Review for Corrective Action**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Potosi provided the 2013 annual report as documentation. The report is also available online to view.

### **§§115.89 – Data Storage, Publication, and Destruction**

☐ Exceeds Standard (substantially exceeds requirement of standard)

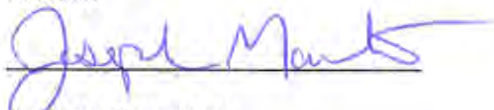
☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

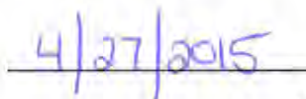
The agency provided documentation of the records disposition schedule that clearly outlines what reports and when they are to be destroyed. The agency provides information on their website, however all personal identifiers are removed and not shown.

#### **AUDITOR CERTIFICATION:**

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.



Auditor Signature



Date



# PREA AUDIT: AUDITOR'S SUMMARY REPORT

## ADULT PRISONS & JAILS

NATIONAL  
PREA  
RESOURCE  
CENTER



**BJA**  
Bureau of Justice Assistance  
U.S. Department of Justice

**[Following information to be populated automatically from pre-audit questionnaire]**

<b>Name of facility:</b>	Tipton Correctional Center		
<b>Physical address:</b>	619 North Osage Avenue Tipton, Missouri 65081		
<b>Date report submitted:</b>	September 21, 2015		
<b>Auditor Information</b>	<b>Joseph Z. Martin</b>		
<b>Address:</b>	374 New Bethel Rd. Fredonia, Ky. 42411		
<b>Email:</b>	Joseph.martin@ky.gov		
<b>Telephone number:</b>	270 388-1048		
<b>Date of facility visit:</b>	July 7 <sup>th</sup> – 9 <sup>th</sup> 2015		
<b>Facility Information</b>	<b>Tipton Correctional Center</b>		
<b>Facility mailing address: (if different from above)</b>	Same		
<b>Telephone number:</b>	660-433-2031		
<b>The facility is:</b>	<input type="checkbox"/> Military	<input type="checkbox"/> County	Federal
	<input type="checkbox"/> Private for profit	<input type="checkbox"/> Municipal	<input checked="" type="checkbox"/> State
	<input type="checkbox"/> Private not for profit		
<b>Facility Type:</b>	<input type="checkbox"/> Jail	<input checked="" type="checkbox"/> Prison	
<b>Name of PREA Compliance Manager:</b>	Cybelle Webber DeputyWarden	<b>Title:</b>	
<b>Email address:</b>	cybelle.webber@doc.mo.gov	<b>Telephone number:</b>	660-433-2031
<b>Agency Information</b>			
<b>Name of agency:</b>	Missouri Department of Corrections		
<b>Governing authority or parent agency: (if applicable)</b>	Missouri Department of Corrections		
<b>Physical address:</b>	2729 Plaza Drive, P.O. Box 236 Jefferson City, MO 65102		
<b>Mailing address: (if different from above)</b>	Same		
<b>Telephone number:</b>	573 751-2389		
<b>Agency Chief Executive Officer</b>			
<b>Name:</b>	George Lombardi	<b>Title:</b>	Director

<b>Email address:</b>	<b>Telephone number:</b>	573 526-6607
<b>Agency-Wide PREA Coordinator</b>		
<b>Name:</b> Vevia Sturm	<b>Title:</b>	PREA Coordinator
<b>Email address:</b> vevia.sturm@doc.mo.gov	<b>Telephone number:</b>	573-522-3335

## AUDIT FINDINGS

### NARRATIVE:

The site visit for the PREA Audit of the Tipton Correctional Center was conducted on July 7-9, 2015. The audit team consisted of the Audit Chair, Joe Martin KDOC/DOJ Certified PREA Auditor with two support staff consisting of Shannon Butrum KDOC/DOJ Certified PREA Auditor and David Meeks KDOC. During the Pre-Audit phase, the team reviewed the standards and documentation provided by TCC completing much of the file review prior to the site visit. Requested follow-up documentation was provided to the team on-site.

An entrance meeting was held at the beginning of the on-site visit with the following staff in attendance: MDOC PREA Coordinator Vevia Sturm, Warden Douglas Prudden, Deputy Warden Tim Burris, Deputy Warden Cybelle Webber, Assistant Warden Cheryl Scherer, Major John Shipman and AOSA Sheri Knipp. Introductions were given and discussion was held of the teams schedule including touring the facility, following the recommended tour guide from the PREA Resource Center, and interviewing the necessary staff and inmates.

During the three day on-site portion of the audit, the team completed file review follow-up, toured the facility and conducted formal staff and inmate interviews. The team interviewed 22 inmates consisting of 11 random inmates from all housing units, 4 disabled and limited English proficient, 4 who disclosed sexual victimization during risk screening, 2 who had reported sexual abuse and 1 LGBTI inmate. In addition, the team interviewed 34 staff which included the Warden, PREA Compliance Manager, 1 Incident Review Team member, 1 that is charged with monitoring retaliation, 1 Human Resources, 5 Medical and Mental Health staff, 11 random staff from each shift, 2 that perform screening for risk of victimization and abusiveness, 2 investigative staff, 3 who supervised inmates in segregation, 3 intermediate or high-level supervisory staff and 3 volunteers.

### DESCRIPTION OF FACILITY CHARACTERISTICS:

The Tipton Correctional Center is a Minimum Security Adult Male facility. It has an operational capacity of 1,222 beds. TCC provides programs for offenders that include: Adult Basic Education, Vocational Education, Upholstery Chair Factory, Restorative Justice, Community Service projects and Puppies for Parole. In addition, TCC has over 100 work release positions with offenders assigned to crews that work along highways and at the State Fair grounds for surrounding cities.

### SUMMARY OF AUDIT FINDINGS:

The audit team found that staff and inmates were educated and had a good general knowledge of PREA. Staff knew their responsibilities and duties while inmates knew their rights and multiple reporting methods.



Standard 115.15 was found to be in non-compliance during the initial audit. After the on-site audit a Corrective Active Plan was developed that included training staff and implementation of partial privacy partitions in Housing Units 1, 2 and 3. The initial Corrective Action Plan was set at 180 days however, TCC has already trained staff and placed specific protocol in place of female staff entering bathrooms as outlined and placed partial privacy partitions in the above mentioned housing units. TCC provided documentation of these requirements and is now in full-compliance with all PREA standards. Each standard below will have justifications for compliance or comments/recommendations for each.

Number of standards exceeded: 1  
Number of standards met: 41  
Number of standards not met: 0  
Not Applicable: 1

**§115.11 - Zero tolerance of sexual abuse and sexual harassment; PREA coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs this standard. The Missouri Department of Corrections has designated a state-wide PREA coordinator and each facility has a designated PREA Compliance Manager.

**§115.12 - Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency contracts with private agencies incorporate that PREA standards must be followed. The agency also has a tool in place that is used when site visits are performed by agency staff. Documentation provided used direct wording.

### **§115.13 – Supervision and Monitoring**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 uses direct language for unannounced rounds and prohibits staff from alerting others of these rounds. The agency has established a staffing plan for each facility. It was found during the audit that the components of section (a) were not being documented as at least being considered on an annual basis. The Division Director issued a directive stating that all components are considered and if any of the information changes it would be considered in reassessing appropriately. In addition, information specifically addressing section (a) will be added to the facilities annual report.

### **§115.14 – Youthful Inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Not Applicable - Youthful offenders are not housed at TCC.

### **§115.15 – Limits to Cross-Gender Viewing and Searches**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policies IS20 1.3 and D1-8.13 Offender Sexual Abuse and Harassment direct that staff of the opposite gender will announce their presence when entering housing units and protocols for searching transgender and intersex inmates. All security staff have been trained on searching cross-gender, transgender and intersex inmates.

Tipton Correctional Center initially during the on-site audit was non-complaint with this standard specifically section (d). TCC has completed its Corrective Action Plan that included placing partial privacy partitions in housing units 1 ,2 and 3. In addition, staff have been trained on the agency's policy of female staff entering bathrooms and specific details have been placed in TCC's SOP's detailing such. Documentation has been received providing all components of the Corrective Action Plan has been completed.



### **§115.16 – Inmates with Disabilities and Inmates who are Limited English Proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment directs this standard. TCC has available Interpreter Services if needed and has transcripts of PREA videos that are available in different languages. In addition, braille PREA education materials are available.

### **§115.17 – Hiring and Promotion Decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D2-2.2 directs background checks for employees while state applications include the components in section (a). Agency policy also directs background checks for contractors. TCC provided documentation of this practice that showed it was institutionalized. The State Employee Handbook includes a continuing affirmative to disclose immediately this type of misconduct.

Staff Human Resources interviews showed good knowledge of this requirement.

### **§115.18 – Upgrades to Facilities and Technology**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D4-4.8 incorporates language for installing or updating monitoring systems. TCC reported that barrier walls in zone 3 and 4 have been lowered in the open bay units to allow greater observation and reduce blind spots.

### **§115.21 – Evidence Protocol and Forensic Medical Examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)



X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policies D1-8.8 and D1.8.13 direct this standard. The agencies medical contract with Corizon includes sexual abuse victims are provides exams at no cost. TCC's Chaplin serves as the facilities victim advocate. Training records show appropriate training for qualification. TCC's reports no sexual abuse victims have required forensic exams but these exams are available when and if needed and direct protocol is included in their Sexual Abuse Coordinated Response.

### **§115.22 – Policies to Ensure Referrals of Allegations for Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policies D1-8.13, D1-8.1 and D1-8.4 direct the components of this standard. The Inspector General's Office has assigned appropriately trained staff to investigate allegations of sexual abuse involving potentially criminal behavior.

### **§115.31 – Employee Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs PREA training for all staff. The Lesson plans for Basic Academy and bi-annual refresher training cover all the components of section (a). This training is tailored to the gender of the inmate population as lesson plans have been developed and is taught for both genders. TCC reports all staff to have received this training and the sampling of documentation and staff interview corroborated this requirement.

### **§115.32– Volunteer and Contractor Training**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs this standard. Curriculum was provided and meets all the components of this standard. TCC provided documentation of Acknowledgement Forms signed from this training. In addition, training for volunteers and contractors is held annually as brochures and information is given to them.

### **§115.33 – Inmate Education**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 and directive from agency head directs this standard. TCC provides PREA education videos for all inmates in addition to brochures and information posted throughout the facility.

Inmate interviews helped determine that inmates were well educated on PREA to include their rights and services available.

### **§115.34 – Specialized Training: Investigations**

X Exceeds Standard (substantially exceeds requirement of standard)

☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs this standard. The Specialized Investigator training course curriculum exceeds components that are covered in this standard. Criminal investigations at TCC are conducted by the Inspector General's office and Administrative investigations are conducted by a Administrative Inquiry Officer, both of which have received PREA Specialized Investigator training.

Investigator interviews showed great knowledge and experience possessed.

### **§115.35 – Specialized training: Medical and mental health care**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)



☐ Does Not Meet Standard (requires corrective action)

TCC's Medical and Mental Health staff have received the specialized training as required by this standard in addition to training required for all as referenced in standard 115.31. TCC provided documentation and lesson plans of this training.

Medical and Mental health staff interviews verified this training.

#### **§115.41 – Screening for Risk of Victimization and Abusiveness**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. The facility utilizes the Adult Internal Risk Assessment as an objective screening instrument. Interviews and documentation confirmed compliance.

#### **§115.42 – Use of Screening Information**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policies, D1-8.13 Offender Sexual Abuse & Harassment and IS5-3.1 Offender Housing Assignments, which cover this standard. The use of the screening instrument was confirmed through the interviews and documentation reviews.

The facility does not currently have any transgender or intersex offenders but does have a committee and policy that outlines the actions that will be taken to confirm compliance.

*TCC currently has no jobs with inmates at high risk of being sexually victimized (sigma) & inmates at high risk of being sexually abusive (alpha) assigned to work together. Staff interviews showed that all jobs at TCC have the potential to have both alphas and sigmas assigned however, few job Supervisors knew the difference and possessed knowledge of what their responsibilities would be if this occurred. Recommended that the inmate status be documented on classification documents and that all job supervisors be trained in proper procedure to ensure the safety of each inmate.*

### **§115.43 – Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Facility indicates that involuntary segregation for offenders at high risk has not been utilized. The policy outlines and confirms compliance that if utilized it would meet the requirements of the standard.

### **§115.51 – Inmate Reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. The agency and facility provide multiple ways for offenders to report. Interviews with offenders confirmed compliance as well as documentation.

Staff can privately report through calling Crime Hotline and writing the Department of Public Safety as well as reporting to the Administrative Staff. Interviews with staff confirmed compliance.

### **§115.52 – Exhaustion of Administrative Remedies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D5-3.2 Offender Grievances, which covers this standard. The facility reported no grievances have been filed regarding sexual abuse.

### **§115.53 – Inmate Access to Outside Confidential Support Services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)



☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Orientation packets, posted flyers, brochures and interviews with offenders confirmed compliance. Offenders have knowledge of the resources available and an understanding of the monitoring and the duty of staff regarding the mandatory reporting laws.

*No information on the Chaplains acting as trained advocates was observed posted in the facility. Recommended that this information be posted in areas of the facility for inmate access.*

### **§115.54 – Third-Party Reporting**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency website has information regarding how to report third-party reports. Throughout the facility there are posted brochures on how to report. Interviews with Offenders confirmed knowledge of this.

### **§115.61 – Staff and Agency Reporting Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Policy requires all staff to immediately report any knowledge or information regarding an incident of sexual abuse or sexual harassment. The policy also requires staff to immediately report retaliation. Interviews confirmed staff are aware of the policy and aware of their duty to report and keep information confidential.

Policy IS11-32 Receiving Screening intake Unit covers the mandatory reporting laws.

### **§115.62 – Agency Protection Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has D1-8.13 Sexual Abuse & Harassment, which covers this standard. Interviews with staff confirmed that immediate action would be taken to protect the offender.

### **§115.63 – Reporting to Other Confinement Facilities**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Documentation reviewed confirmed compliance. The policy outlines the requirements of notification between facilities and documentation confirmed compliance with the time frame.

### **§115.64 – Staff First Responder Duties**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. TCC utilizes a Coordinated Response Protocol that outlines first responder duties. Staff interviews confirmed compliance and awareness of their responsibilities. Documentation also revealed first responders as both security and non-security staff.

### **§115.65 – Coordinated Response**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The Coordinated Response to Offender Sexual Abuse is the institutional plan. This plan outlines the duties of first responders, medical and mental health staff, investigators and facility leadership in response to an incident of sexual abuse.



*It is recommended that information on the victim advocate trained Chaplains be added to the coordinated response plan to include who is on call with their contact information.*

#### **§115.66 – Preservation of ability to protect inmates from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The facility provided an agreement between the Missouri DOC and the Missouri Corrections Officers Association, with an effective date of 10/01/2014 through 09/30/2018.

#### **§115.67 – Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13, Offender Sexual Abuse & Harassment, which covers this standard. Documentation provided confirms monitoring for 90 days with periodic status checks every 30 days for inmates. Staff interviews confirmed monitoring would exceed 90 days if needed.

#### **§115.68 – Post-Allegation Protective Custody**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

The agency has policy, D1-8.13 Offender Sexual Abuse & Harassment, which covers this standard. Facility indicates that segregated housing to protect an inmate that has alleged to have suffered sexual abuse has not been utilized and a review of housing assignments confirmed. The policy outlines and confirms compliance that if utilized it would meet the requirements of the standard.

#### **§115.71 – Criminal and Administrative Agency Investigations**



☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Missouri Department of Corrections policy D1.-8.4 Administrative Inquires outlines this standard clearly. Documentation provided included investigations that were thorough and complete. Interviews with investigative staff proved good knowledge possessed of their duties and responsibilities of this standard and line staff interviews showed that knowledge was possessed of this standard.

Criminal Investigations are conducted by the Inspector General's Office who in turn reports to the Department Director. The Inspector General's Office is a part of the Missouri Department of Corrections. Administrative Investigations are conducted by facility staff. Both have received training in the requirements of standard 115.34

#### **§115.72 – Evidentiary Standard for Administrative Investigations**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Missouri Department of Corrections agency policy D1-8.4 Administrative Inquiries outlines that no standard higher than a preponderance of the evidence is used when determining the outcome of allegations of sexual abuse or sexual harassment.

Review of documentation and Investigative staff interviews showed good practice and knowledge of this standard.

#### **§115.73 – Reporting to Inmate**

☐ Exceeds Standard (substantially exceeds requirement of standard)

X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines the reporting requirements of this standard. Documentation provided showed examples of demonstrated practice. Interviews with staff and inmates corroborated that notifying inmates who report sexual abuse is a common practice at the facility.

### **§115.76 – Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard to include termination as the presumptive disciplinary sanction for staff who have engaged in sexual abuse. The facility reported that no staff had been terminated for violating sexual abuse or sexual harassment policies.

### **§115.77 – Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policies D2-13.1 Volunteers and D1-8.13 Offender Sexual Abuse and Harassment both outline this standard. The facility reported no incidents of where a contractor or volunteer had engaged in sexual abuse of an inmate.

The Warden's interview indicated there would be remedial measures in place to prohibit contact if an allegation of sexual abuse and/or sexual harassment was made to prohibit contact for an investigation to be completed.

### **§115.78 – Disciplinary sanctions for inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment was provided outlining the sections of the standard. TCC provided documentation of an occurrence where a perpetrator was adjudicated for inmate on inmate sexual abuse and input had been received from Mental Health staff prior to the finding.



### **§115.81 – Medical and mental health screenings; history of sexual abuse**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Policy IS11-32 Receiving Screening-Intake Center outlines this standard. The facility indicated that 100% of its inmates had at least been offered follow-up services for prior sexual victimization or perpetration. The facility provided screening logs to indicate this practice. A memo was also provided stating that the facility had not any incidents requiring Medical or Mental Health to obtain consent from an offender.

Medical and Mental Health staff interviews showed good knowledge possessed of this standard along with their responsibilities and duties.

### **§115.82 – Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs this standard. The facility provided documentation to show it provides timely, unimpeded emergency medical treatment to victims of sexual abuse. This includes any necessary treatment determined by medical staff's professional judgment to include education and timely access to sexually transmitted infections prophylaxis free of cost to the inmate.

Medical and Mental Health staff interviews corroborated that emergency medical and mental health services are readily available.

### **§115.83 – Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 directs this standard. TCC provided documentation of Mental Health and/or Medical follow ups as well as referrals for inmates who have been sexually victimized

and have perpetrated sexual abuse. The facility does not house female inmates making sections (d) and (e) inapplicable.

Medical and Mental Health staff interviews showed good general knowledge of duties and responsibilities.

#### **§115.86 – Sexual abuse incident reviews**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Sexual Abuse and Harassment outlines the standard. The facility provided copies of the departmental Incident Review forms which incorporate all the components of this standard for assessing and considering.. The facility showed that is in compliance by the practice of having medical or mental health staff sit in on the debriefing along with other appropriate staff.

#### **§115.87 – Data Collection**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

The agency meets the requirements of this standard. All aggregated data is stored and used appropriately. The Survey of Sexual Violence was submitted to the DOJ for 2014.

#### **§115.88 – Data Review for Corrective Action**

☐ Exceeds Standard (substantially exceeds requirement of standard)

☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment outlines this standard. The agency meets the requirements of this standard as it completes an annual report and the report is published on its website. This report also includes any necessary redactments.



## §115.89 – Data Storage, Publication, and Destruction

☐ Exceeds Standard (substantially exceeds requirement of standard)

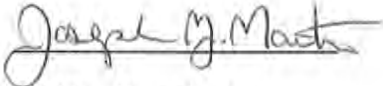
X Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

Agency policy D1-8.13 Offender Sexual Abuse and Harassment directs this standard. A copy of the retention schedule directs storage for 50 years. Upon review of the annual report, no personal identifiers are shown.

### AUDITOR CERTIFICATION:

The auditor certifies that the contents of the report are accurate to the best of his/her knowledge and no conflict of interest exists with respect to his or her ability to conduct an audit of the agency under review.



Auditor Signature

September 21, 2015

Date

**PREA AUDIT REPORT**    ☐ Interim    ☒ Final  
**ADULT PRISONS & JAILS**

**Date of report:** December 28, 2015

<b>Auditor Information</b>			
<b>Auditor name:</b> Elisabeth Copeland			
<b>Address:</b> 714 SW Jackson, Suite 300, Topeka, KS 66603			
<b>Email:</b> Elisabeth.Copeland@doc.ks.gov			
<b>Telephone number:</b> 785-291-3074			
<b>Date of facility visit:</b> December 8 – 10, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Western Missouri Reception Diagnostic and Correctional Center			
<b>Facility physical address:</b> 3401 Faraon Street, St. Joseph, MO 64506			
<b>Facility mailing address:</b> <i>(if different from above)</i> Click here to enter text.			
<b>Facility telephone number:</b> 817-387-2158			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input checked="" type="checkbox"/> Prison	<input type="checkbox"/> Jail	
<b>Name of facility's Chief Executive Officer:</b> Ryan Crews			
<b>Number of staff assigned to the facility in the last 12 months:</b> 547			
<b>Designed facility capacity:</b> 1968			
<b>Current population of facility:</b> 2051			
<b>Facility security levels/inmate custody levels:</b> Minimum - Maximum			
<b>Age range of the population:</b> 18 - 74			
<b>Name of PREA Compliance Manager:</b> Sherie Korneman		<b>Title:</b> Deputy Warden	
<b>Email address:</b> Sherie.Korneman@doc.mo.gov		<b>Telephone number:</b> 816-387-2158, ext. 2202	
<b>Agency Information</b>			
<b>Name of agency:</b> Western Missouri Reception Diagnostic and Correctional Center			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Missouri Department of Corrections			
<b>Physical address:</b> 2729 Plaza Drive, Jefferson City, MO 65102			
<b>Mailing address:</b> <i>(if different from above)</i> P. O. Box 236, Jefferson City, MO 65102			
<b>Telephone number:</b> 573-751-2389			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> George Lombardi		<b>Title:</b> Director	
<b>Email address:</b> George.Lombardi@doc.mo.gov		<b>Telephone number:</b> 573-751-2389	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Vevia Sturm		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> Vevia.Sturm@doc.mo.gov		<b>Telephone number:</b> 573-751-2389	

## AUDIT FINDINGS

### NARRATIVE

#### PRE-AUDIT

A Notice of PREA Audit was sent to the Western Missouri Reception Diagnostic and Correctional Center (WRDCC) on October 28, 2016 via the Missouri Department of Corrections Statewide PREA Coordinator, Vevia Sturm. Notices were to be posted in all living units, program areas, recreation areas and any other areas that offenders would gather. The notice also contained contact information of the auditor and advised staff and offenders that the onsite portion of the PREA audit will be conducted on December 8 – 10, 2015. It should be noted that this audit is being conducted as part of five state consortium consisting of Nebraska, Kansas, Missouri, Kentucky and Louisiana. Ms. Sturm forwarded the Notice of PREA Auditor to the Site Coordinator of WRDCC. On October 29, 2016 the Site Coordinator, Sherie Korneman and this auditor made contact and established date the Pre-Audit Questionnaire would be sent.

On November 20, 2016, a flash drive containing WRDCC's Pre-Audit Questionnaire was received. The flash drive contained department and agency policies, curriculum and other supporting documentation. The files were divided up by standard and were easy to read and navigate.

The auditor reviewed the provided documentation and began completing the Auditor's Compliance Tool to determine a baseline for compliance and to formulate questions for the onsite portion of the audit.

On December 4, 2015, a tentative agenda for the PREA audit was sent the Site Coordinator. This agenda outlined the when the auditing would be on site, the types of staff and inmates that would be interviewed and when the audit would conclude. The Site Coordinator was advised of which specialized staff would be interviewed as well as which specialized inmate populations would be interviewed.

#### ONSITE

The auditor was accompanied on the site visit by another certified PREA auditor, Mark Mora and two additional members of the Kansas PREA team, Karen Williams and Joni Foster-Webster. The auditors were greeted and given an orientation to the facility by the Warden Ryan Crews and Deputy Warden I(Site Coordinator) Sherie Korneman as well as other Executive Team members. The agency PREA Coordinator Vevia Sturm was also in attendance throughout the audit process. After the initial meeting, a detailed tour was provided to the auditing team.

Warden Ryan Crews and Site Coordinator Sherie Korneman lead the onsite tour. The tour began with the Diagnostic Unit. The team viewed the intake room and was viewed orientation packets. These packets included information on PREA. The intake officer was also able to show the orientation packets were available in various languages and in large print. The auditor also viewed the strip out room and viewed appropriate barriers to prevent cross-gender viewing. Administrative staff advised this post was manned only by male staff. During this portion of the tour, the auditor was able to observe the video educating new intakes on PREA being played.

This tour also included the four housing units. (One housing unit contained the Substance Abuse Treatment program.) The auditor viewed camera placements, showers/restrooms and observed cross-gendered announcements being made to offenders. PREA reporting information and outside emotional support information was clearly marked on bulletin boards in each living unit. The auditor spoke with several offenders about the tour and it clear they were aware a PREA audit was being conducted. Several comments from the offenders included, "yeah, we knew you were coming" and "Is this that PREA audit we were told about?" In the open dorm units, PREA barriers (wooden structures that can be moved in front of showers and toilet areas) were present. It was also determined that cross-gender viewing into the shower and toilet areas could not be done from the second tier.

In the segregation units, the auditor found that cross-gender viewing was occurring as the showers were clearly open and visible to anyone walking by. Since female staff work in these units, this situation was discussed with the administrative staff. The Warden contacted maintenance and requested that metal barriers be installed to prevent the viewing of genitalia while the offender was showering. Work on these barriers began immediately.

In addition to the living units the medical area, outside recreation, inside recreation, dining areas, library, programs, and control posts were also toured. PREA reporting information and emotional support services were found on every bulletin board and were clearly marked. Camera placements were also viewed and views were checked in the control center. WRDCC has made sure that no shower stalls or toilet areas could be viewed by anyone watching the cameras as those areas are blurred out.

After the tour, interviews were conducted with staff and inmates.



Immediately after the tour, the Site Coordinator provided the auditing team with staff rosters from all three shifts and provided a list of specialized staff. The auditor then randomly selected three staff from each shift, as well as established times to interview specialized staff.

The Site Coordinator provided the auditor with housing units' rosters and staff rosters for all three shifts. In reviewing the housing rosters the auditor randomly selected ten inmates for a total of 40 inmates to be interviewed. The auditor then assigned two housing units to Mark Mora for interview.

This auditor interviewed inmates in Housing Units #6 and #11. While 20 random inmates were selected, a significant portion refused to participate in the interview process. In order to increase the number of random inmate interviews, this auditor selected an additional seven inmates only to have more refusals. In the end only nine inmates were interviewed out of housing units #6 and #11.

Twenty random inmates were selected to be interviewed in Housing Units #1 and #10. There were no inmate refusals in these two housing units; however, some were not available due to work release.

WRDCC provided appropriate accommodations for the auditors to conduct inmate and staff interviews. The auditor was given access to staff files, inmate files and any documentation that was requested. Facility staff was great to work with and were very accommodating. The Site Coordinator and Warden were readily available to answer any questions and assist in any way. Staff at WRDCC was extremely helpful and polite throughout the entire process.

Auditors interviewed a total of 25 inmates that had various lengths of stay. The auditors interviewed a total of 20 staff to include the Warden, Site Coordinator, Investigator, Mental Health Staff, Human Resources staff, Intake Staff, as well as random staff from all three shifts.

Prior to the exit interview, the auditor reviewed onsite documentation and discussed results of interviews conducted by certified auditor Mark Mora. We compared notes and reviewed standards. There was an exit interview conducted at the end of the site visit.

#### POST AUDIT

After the onsite portion of the PREA audit, this auditor reviewed the notes from the tour; all interviews conducted and did another review of the supporting documentation. Work on the final audit report began.

On December 24, 2015, the auditor received pictures of completed shower barriers in the segregation units. The pictures are now a part of the auditor's permanent file.

On December 31, 2015 the PREA audit report was submitted to the PREA Resource Center for feedback as a requirement of certification for this auditor.

## DESCRIPTION OF FACILITY CHARACTERISTICS

The Western Reception Diagnostic and Correctional Center is located in St. Joseph, Missouri and officially opened in September of 1999. The reception and diagnostic facility serves an area comprised of 30 counties in the western region of the state of Missouri receiving newly sentenced offenders, probation/parole returns and treatment offenders.

The current population at WRDCC is 2,051 offenders. During the past 12 months 7,738 offenders have been admitted to the facility. Of this number 6,660 admitted had a length of stay longer than 30 days. The age range of the current offender population is 18 – 74 with custody levels being from minimum custody to maximum custody.

WRDCC has 547 employees who have contact with offenders. This staff is responsible for the security of 19 buildings, which include four housing units, and 72 segregation cells. WRDCC also has two investigators onsite to investigate allegations of sexual abuse.

In addition to the 546 employees, WRDCC also has 774 volunteers and individual contractors who are currently authorized to enter the facility.

WRDCC also has an onsite medical facility that provides most medical services with a 24 hour infirmary care. The onsite medical facility does not conduct sexual assault medical exams. All sexual assault medical exams are done at MOSIAC Life Care.

The total acreage of WRDCC is 168 acres, 71 of which are located within a secure perimeter. The current complex has an official capacity of 1,968 beds and comprised of three major components: the reception and diagnostic center, a treatment center, and general population housing units.

The center piece of the facility is the reception and diagnostic center. The three-story 220,000 square foot building houses the facility's administrative offices, control center, medical facilities, food services operations, visiting room, receiving area and diagnostic offices. A five story structure connected to the main reception and diagnostic building provides secure housing for 529 offenders, with additional saturation beds if needed, who are undergoing diagnostic screening prior to their initial institutional assignment. Staff assigned to work in this maximum security area utilizes electronic security systems to monitor and control offender movement throughout the complex. All diagnostic unit processing, which takes approximately 40 days (on average), is conducted within the diagnostic unit. The diagnostic unit processes approximately 425 offenders per month. Offenders are screened for medical needs, mental health needs, substance abuse treatment needs, education levels, vocational skills, and custody levels. Since opening in September 1999 WRDCC has processed over 50,000 offenders.

The Western Region Treatment Center, which is part of the greater facility, houses 595 offenders participating in 120 or 180 day treatment for alcohol and substance abuse. The facility utilizes a modified therapeutic community model along with small group programming to deliver treatment services.

WRDCC's two general population housing units house 700 general population offenders along with additional 50 offenders participating in substance abuse treatment in the Partial Day Treatment Program. Offenders assigned to the general population are minimum security offenders who are assigned to institutional jobs and may be assigned to the work release program if they meet the established criteria. There are also 56 diagnostic overflow beds in one of the general population units.

Included in one of the general population units is the alternate Department of Corrections male juvenile offender unit. Coming on line in June 2010, this housing unit can accommodate up to twelve juvenile offenders. This unit is located in the lower level of Housing Unit #11 and includes an education classroom, clothing issue room, and a multi-purpose room for medical appointments and meetings/counseling with staff. It should be noted that this site is currently not used full time as the primary site is located at Farmington Correctional Center.

The facility offers a variety of programs. The following is a quick overview of these programs:

1. Work Release: Offenders have the opportunity to learn good work habits and earn \$7.50 per day as opposed to \$7.50/\$8.50 per month for most institutional job assignments. Agencies utilizing work release offenders from WRDCC include the Missouri Department of Transportation, Missouri Air National Guard, Northwest Missouri Psychiatric Rehabilitation Center, City of St. Joseph, and the Second Harvest Food Bank.
2. Puppies for Parole: This program began on July 7, 2010. Since the start of this program over 200 dogs have been trained. This is a cooperative venture with the animal shelter and other community organizations to provide a safe, clean, and humane environment for the care and training of rescued dogs with the hope of making them more adoptable. This program is in Housing Unit #6.
3. Transitional Housing Unit: When offenders are six months from their release date they are assigned to this unit. With their case manager, they review what they have accomplished during their incarceration, what they still need to work on, and what assistance they will require to successfully return to society. This unit is located on the 2<sup>nd</sup> and 3<sup>rd</sup> floors of Housing Unit #6. It currently

has 256 offenders benefiting from the services provided.

- If offenders have not attended programming prior to assignment to the Transitional Housing Unit, offenders will be assigned to the CORE programs. These programs included:
  - a. Pathway to Change
  - b. Inside Out Dads
  - c. Anger Management
  - d. Impact of Crime on Victims

WRDCC continues to provide excellent public safety through secure and safe confinement, holding offenders accountable for their behavior, and preparing the offenders to be law abiding and productive citizens. The work they do supports the Missouri Department of Corrections vision, "A Safer Missouri and the Standard of Excellence in Corrections."

## SUMMARY OF AUDIT FINDINGS

It's clear that WRDCC believes that incarcerated individuals have the right to be free from sexual abuse and sexual harassment. This zero-tolerance culture is evident in the policies of the agency, the actions of WRDCC leadership as well as the knowledge the staff demonstrated of PREA. WRDCC leadership was quick to respond to the cross-gender viewing of the showers in the segregation units. They were very open with the auditing team and asked numerous questions. Staff was able to articulate the agencies coordinated response to sexual abuse and harassment and also expressed their appreciation of the leadership's buy-in into PREA implementation. Several staff shared that the warden spoke at PREA trainings and stressed the importance of supporting a zero-tolerance culture.

The overall theme of the interviews with inmates included feeling safe at the facility and the belief that staff takes reports of sexual abuse seriously. The inmates were able to explain how to report incidents of sexual abuse and harassment and were able to discuss how they were exposed to PREA education upon intake. While some stated they could not remember the PREA video, they did state that their case managers discussed PREA reporting with them. They reported that retaliation when making an allegation was not tolerated. All inmates reported they knew that opposite gender staff announced themselves at the beginning of each shift and felt they had privacy when using the restroom, changing clothes and using the shower. They also reported that there were times when cross-gender announcements were made throughout the day if program staff came into the housing units.

Staff knew their responsibilities to prevent, detect, and respond to incidents of sexual abuse and harassment. Staff was able to articulate the coordinated response to sexual abuse and harassment. They knew to separate the victim from the alleged perpetrator, secure the scene and to contact their supervisor. They stated that all reports would be documented by the end of shift. They also stated that if they received knowledge of someone being in imminent danger they would immediately secure the safety of that individual. It is clear that there is a zero -tolerance culture at WRDCC.

Interviews with specialized staff were completed and the results were positive and supported the zero-tolerance culture. Each knew their role and responsibilities as it pertains to PREA compliance and documentation. They articulated the coordinated response and the expectations that staff would follow all policies. Administrative staff was very open to any suggestions the auditors had when concerns were found on the tour. One example was improving the privacy of showers located in segregated housing to prevent cross-gender viewing. Administration was quick to fix the situation and wanted the auditors input.

Documentation provided in the pre-audit questionnaire was well organized and easy to read. WRDCC was found to be in compliance with each PREA standard.

Number of standards exceeded: 0

Number of standards met: 44

Number of standards not met: 0

Number of standards not applicable: 0

### **Standard 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

#### **DOCUMENTATION REVIEW:**

WRDCC has written policy mandating zero tolerance toward all forms of sexual abuse and sexual harassment. (See D1-8.13 Offender Sexual Abuse and Harassment, Section III (A)(2), page 6: "The department has zero tolerance for all forms of offender sexual abuse, harassment, and retaliation." In this same policy the agency outlines how they will implement the agency's approach to preventing, detecting, and responding to sexual abuse and sexual harassment. This outline can be found starting on page 6 and ends on page 27.

WRDCC also has an additional policy that addresses zero tolerance towards all forms of sexual abuse and sexual harassment. (See D1-8.6 Offender Physical Abuse, Section III (A)(3), page 3: "The department has zero tolerance for all forms of offender abuse and retaliation." In III (B)(1) page 3 it further states, "Failure to report that an offender has been abused is a class A misdemeanor."

Missouri Department of Corrections (MDOC) has designated an upper-level, agency wide PREA Coordinator. The position of the PREA Coordinator is listed in the MDOC's organizational chart and is under the department's General Counsel. In addition, WRDCC has also designated a PREA compliance manager. This position is also listed in the facility's organizational chart and reports directly to the Warden of WRDCC. Both positions are required per policy D1-1.13, Offender Sexual Abuse and Harassment, Section III (A)(4) and (5), page 6.

#### **INTERVIEWS:**

The PREA compliance manager, also known as the Site Coordinator, reports that she has sufficient time and authority to coordinate the facility's efforts to comply with the PREA standards. It should be noted that in policy D1-8.13 Offender Sexual Abuse and Harassment, page 3, PREA Site Coordinator is defined as follows, "A facility employee at the level of deputy warden or associate superintendent or higher; who is responsible for ensuring compliance of the PREA standards at his assigned facility."

#### **RECOMMENDATION:**

None

### **Standard 115.12 Contracting with other entities for the confinement of inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

#### DOCUMENTATION REVIEW:

MDOC's policy D1-8.13, Offender Sexual Abuse and Harassment, Section III (9), page 7, states, "All residential contractors shall adopt and comply with PREA standards as outlined in their contract with the department..." The policy also states that Chief Administrative Officer or designee shall regularly audit residential contractors to ensure compliance with the PREA standards and the department may enter into contracts with an entity that fails to comply with PREA standards only in emergency circumstances.

It should be noted that while the parent agency, MDOC, contracts for confinement of inmates, WRDCC does not.

#### INTERVIEWS:

N/A

#### RECOMMENDATION:

None

#### Standard 115.13 Supervision and monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

#### DOCUMENTATION REVIEW:

MDOC requires each facility it operates to develop, document, and make its best efforts to comply on a regular basis with a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring, to protect inmates against abuse. Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (10)(11), page 7 states, "The department shall maintain staffing plans for each facility that provides adequate levels of staffing to protect offenders against sexual abuse. The staffing plan shall consider the facility's physical plant to include but not limited to blind spots or areas where staff members or offenders may be isolated, the composition of the offender populations, the prevalence of substantiated and unsubstantiated offender sexual allegations. Each facility shall comply with the staffing plan on a regular basis, deviations from the staffing plan shall be documented and justification for deviations noted." WRDCC SOP D1-8.13, page 7 states the same.

Each time the staffing plan is not complied with, WRDCC documents and justifies all deviations from the staffing plan. WRDCC SOP D1-8.13, page 7, states, "The shift supervisor is to submit written documentation to the PREA site coordinator any time there is a deviation from the staffing plan. A copy of the documentation goes to the chief of custody."

WRDCC provided a copy of meeting minutes dated March 27, 2015. This meeting was the PREA Annual Facility Assessment. Meeting minutes reflected that administrative staff discussed staffing levels, video monitoring, no findings of inadequacy from Federal investigative agencies, physical plan layouts, including blind spots, and PREA investigations conducted in 2014.

#### INTERVIEWS:

During the interviews with WRDCC's Warden and PREA Site Coordinator, both were able to articulate the eleven elements of the staffing plan. It was learned that the parent agency, MDOC, develops the statewide staffing plan and that each facility is then allowed to change staffing numbers to meet their own needs. It was also shared that this facility "...does not have to offer mandatory overtime very often."



While interviewing an intermediate supervisor, it was learned that the practice of WRDCC is to have unannounced rounds for every shift. They shared that these types of round occur daily and they are documented in housing unit chronos. They stated that staff is aware that unannounced rounds will happen on every shift; however, they do not know when it will happen.

\*\*\*\*\*Auditor reviewed six days of housing unit chronos that supports unannounced PREA rounds being conducted on every shift.

#### RECOMMENDATION:

None

#### Standard 115.14 Youthful inmates

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In the past 12 months, only two youthful offenders have been housed at WRDCC. On the day of the audit no youthful offenders were housed at this facility.

#### DOCUMENTATION REVIEW:

WRDCC policy IS & SOP 5-1.1 Diagnostic Center Reception and Orientation, Section III (7), page 8 outlines the steps that must be taken when a records officer determines an offender is a youthful offender.

If a youthful offender is placed at WRDCC, the facility has policies in place that prohibit placing youthful offenders in a housing unit in which they will have sight, sound, or physical contact with any adult inmate through use of a shared dayroom or other common, space, shower area, or sleeping quarters.

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III, (C)(4), page 11 states, "A youthful offender shall not be placed in a housing unit which he shall have sight, sound, or physical contact with any adult offender through use of a shared dayroom or other common space, shower area, or sleeping quarters..."

This is also required by Missouri law: Chapter 217, Department of Corrections, Section 217.345, dated August 28, 2013

WRDCC policy IS & SOP 5-3.1 Offender Housing Assignments, Section III (2)(f), page 3 states, "Housing Unit 11-1EB has been designated for the housing of youthful offenders."

WRDCC also issued a memo dated October 26, 2015 that outlines housing assignments if multiple offenders are housed in the juvenile area. This memo outlines bunk assignments placed on their internal classification of risk for sexual abuse and victimization.

This facility has separate operational memos for the juvenile housing unit that outlines movement, programs, and recreation.

#### ONSITE:

Auditor toured Housing Unit 11-1EB on the day of the audit. This housing unit is located out of sight and sound of adult inmates, which includes a separate entrance to unit and a separate recreation area. This unit also has its own classroom.

## INTERVIEWS:

This auditor interviewed the staff member that oversees youthful offenders when housed at WRDCC. This staff member stated if movement was to occur, the adult yard is closed and movement is done under direct supervision of staff. She also indicated that movement is also done through entrances separate from the adult offenders. It was reported that supervision of youthful offenders is direct supervision 24 hours a day and that isolation is not used.

## RECOMMENDATION:

None

### Standard 115.15 Limits to cross-gender viewing and searches

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC is a male only facility and does not conduct cross-gender strip or cross-gender visual body cavity searches of inmates.

## DOCUMENTATION REVIEW:

The facility does not permit cross-gender viewing or searching.

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (C) (7), page 12 – 13 states, "Cross-gender strip searches are not allowed except in exigent circumstances. All cross-gender strip searches shall be documented as outlined in the institutional services procedure...Offenders shall be allowed to shower, perform bodily functions, and change clothing without non-medical staff of opposite gender viewing their breast, buttock, or genitalia, except in exigent circumstances, or when such viewing is incidental to routine cell checks...Staff of the opposite gender shall announce their presence prior to entering an offender housing unit...Announcements shall be recorded...If a staff member of the opposite gender is required to venture past privacy barriers, and no exigent circumstances exist, the staff shall verbally announce their presence to the offenders and allow the offenders to seek privacy from the staff..."

In the past 12 months there have been no cross-gender strip searches or cross-gender visual body cavity search. The facility did provide an example of the log that would be used if this would occur.

Policy D4-4.8 Security Camera Operations, Section III (B), page 4 states "As authorized by the CAO, stationary security cameras should be positioned where placement will enhance security operations as to view live monitoring of visual images in areas where offenders may be located...Security cameras may be placed in restroom/shower areas when barriers or camera positioning prevents the capture of images of genitals, buttocks, or female breasts." On page 5 of this same policy it states, "The CAO will designate authorized staff to review visual images at the original source as it relates to their assigned job duties as outlined in standard operating procedures. Access to visual images and recordings should be limited in order to maintain integrity and security. Custody posts designated for the specific purpose of viewing offender confinement within living environments where use of restroom, showers, strip cells, etc., occur shall be designated as same gender posts with the approval from the appropriate deputy division director."

WRDCC has also implemented additional policies that allow inmates to shower, perform bodily functions, and change clothing without non-medical staff of the opposite gender viewing their genitals. IS & SOP version of 6-1.3 Offender Personal Appearance and Grooming, Section III (A)(1) Offenders must be dressed at all times as nudity is not permitted at any time other than when taking a shower or to address hygienic and bodily functions. (4) Offenders should use privacy barriers provided when using the restroom and when changing clothes.

Auditor reviewed Warden meeting minutes dated April 4, 2014. In regards to cross-gender announcements, the minutes read, "Mr. Dormire instructed Wardens to revise their announcing presence of cross-gendered staff protocol. Institutions were required to announce in the housing units at the beginning of every shift, except midnight shift, that male and female staff would be working the shift. The protocol has been revised to only require an announcement when a staff member of the opposite gender enters the housing unit; once this announcement is made another announcement is not required for the remainder of that shift in that unit. Wardens were reminded that the announcement must be logged on the chronological log by the person make the announcement with the date and time."

The facility has a policy prohibiting staff from searching or physically examining transgender or intersex inmate for the sole purpose of determining the inmate's genital status. Policy SOP D1-8.13 Offender Sexual Abuse and Harassment, Section III, (C) (7c) states, "Staff members shall not perform strip – or pat-down searches or conduct physical examination for the sole purpose of determining an offender's genital status in accordance with the institutional services procedures regarding searches, reception and orientation, and receiving screening intake center."

This is also prohibited in policy IS & SOP 11-34.I Health Assessment and/or Physical Examination at Reception, page 5 and in IS & SOP 20-1.3 Searches, page 16.

Also in policy IS & SOP 20-1.3 Searches, page 17, it reads, "Gender Unknown Through Pat Search: At the diagnostic center, if the gender of the offender is unknown, a female staff will be assigned to perform the pat search." On page 17 it also reads, "Transgender or Intersex Thorough Pat Search: When thorough pat searching a transgender or intersex male offender's upper torso, male staff member will utilize the female offender search technique."

Training requirements for cross-gender pat down searches of transgender and intersex offenders can also be found in SOP D1-8.13 Offender Sexual Abuse and Harassment, page 13. Auditor reviewed MDOC statewide lesson plan titled Institutional Searches dated May 2014. Instructions from cross-gender searches can be found on pages 13-14; Transcript for the Thorough Male on Female Pat Searches can be found on pages 16-17; Transcript for the Thorough Female on Male Pat Search can be found on pages 14 -16 and the Transcript for Transgender, Intersex or Gender Unknown Searches can be found on pages 20 -21 of the curriculum. WRDCC provided training records showing that 756 participants were trained in this curriculum from October 2014 – October 2015.

#### ONSITE:

During the tour of the facility, auditor observed the PREA barriers in the living units. These are wooden barriers that inmates can pull in front the toilet and shower that would prevent staff from viewing their genitals. Staff can observe inmate feet and shoulder areas.

WRDCC currently does not have gender specific posts. Although they do have duties that are gender specific. The Warden advised the facility rarely has females bid for these posts as they involve strip searches (which cross gender strip searches are forbidden). We toured the work release trailer and were advised that male staff worked this post.

Auditor also observed several control centers where video monitoring occurred. Any camera that was positioned to a single cell had the toilet areas blocked from viewing.

In the segregation units, it was discovered that shower stalls had open viewing. The facility began correcting this concern while onsite. This auditor is now in possession of photographs showing the work is completed and cross-gender viewing is now prevented in these housing units.

#### INTERVIEWS:

Staff interviewed all stated that cross-gender pat searches were forbidden at WRDCC unless there was an emergency situation. They also shared that they received refresher training on pat searches within the past year. Staff also stated that if a female was going to be working in the living units that an announcement was made at the beginning of each shift. Many staff also shared that if a female was going to enter the shower areas for any reason, they always announced their presence. They stated the only time this would not occur if female staff felt there was something "going on" in the shower areas.

Inmates stated that although they did not hear the announcements of female staff working in their housing units they know the announcements are made at the beginning of each shift.

#### RECOMMENDATION:

None

## **Standard 115.16 Inmates with disabilities and inmates who are limited English proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has established procedures to provide disabled inmates and inmates with limited English proficiency equal opportunities to participate in or benefit from all aspects of the agency's efforts to prevent, detect, and respond to sexual abuse and sexual harassment.

### **DOCUMENTATION REVIEW:**

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (C) 6, page 12, states "The department shall provide PREA related education in formats accessible to all offenders including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to offenders who have limited reading skills in accordance with the department's procedures....Offenders who have limited English proficiency shall be provided a copy of the video transcript and the PREA offender brochure in their native language...If the documents are unable to be translated as a recognized language the departments PREA site coordinator or designee shall utilize an interpreter to assist the offender in understanding the information provided."

WRDCC provided examples of PREA Brochures and Acknowledgement Forms in the following languages: English, Japanese, Servo Croatian, Spanish, Vietnamese, Russian, Simplified Chinese, Traditional Chinese, Large Print and Braille. PREA posters were in English and Spanish.

WRDCC also has policies that address working with Deaf and Hard of Hearing Offenders (D5-5.1), Disabled Offenders (D5-5.2) and Blind and Visually Impaired Offenders (D5-5.3)

Auditor reviewed the following contracts: Sign Language Interpretive Services (3/31/2015), Language Interpreter – Verbal (6/30/2015), Written Language Translation Services (4/30/2017), and Telephone Based Interpretive Services (6/30/2015).

WRDCC provided an invoice dated 6/22/15 for the translation of a PREA assessment by Global Village Language Center.

Auditor also reviewed lesson plan "Accommodating Special Needs and ADA Guidelines" dated July 2015. WRDCC provided training logs showing that 409 participants were trained in this curriculum from January 2015 – October 2015.

### **ONSITE:**

Auditor viewed various intake packets in the Reception Diagnostic Center in different languages. PREA posters were located throughout the facility in English and Spanish.

### **INTERVIEWS:**

During staff interviews, most stated they would only use an inmate interpreter in emergency situations only – and only if it involved the safety of the inmate. All staff indicated that interpreters, either bilingual staff or interpreters outside the facility, were available other than using inmates to translate.

Auditor was advised that on the day of the audit there were no limited English proficient or disabled inmates housed at WRDCC.

### **RECOMMENDATIONS:**

Upon reviewing the contracts for interpretive services, it was discovered that these contracts automatically renewed for only three years with potential expiration dates in 2015. It is recommended that these contracts be reviewed to determine if they can be extended another three years.

### Standard 115.17 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has several policies in place that prohibits hiring or promoting anyone who may have contact with inmates and prohibits enlisting the services of any contractor, volunteer, or intern who has engaged in sexual abuse of an inmate.

#### DOCUMENTATION REVIEW:

Policy DI-8.13 Offender Sexual Abuse and Harassment, Section III (B), pages 7 – 8 states, "Department staff members shall not hire or promote any person, employee, or enlist the services of any contractor that may have contact with an offender when it is known that he has engaged in sexual abuse with an offender..." The policy further states, "Department staff members shall consider any incidents of sexual harassment in determining whether to hire or promote any person or enlist the services of any contractor..." In addition, "Before hiring new employees the human resources staff members or designee shall perform a criminal background records check and contact all prior institutional employers when possible, for information on substantiated allegations of sexual abuse or any resignation during a pending investigation of an allegation of sexual abuse..."

The following hiring policies also have a PREA component: D2-2.2 Background Investigations, pages 2, 4, 5; D2-2.8 Promotional Appointment, page 3; D2-2.10 Re-Employment Appointment, page 3; D2-13.1 Volunteers, page 6; D2-13.2 Student Interns, page 4.

State HR Director sent an email dated 12/1/2014 to all facility Human Resources divisions outlining ineligibility of applicants with substantiated allegations or resigned during an investigation.

Another email from MDOC administration dated 5/16/2015 was to all contractors advising them that if a potential applicant has a substantiated case or resigned during an investigation for such, they are ineligible to be inside MDOC facilities.

A memo dated 4/24/2015 to the HSH of Corizon Health advised them to run a background check on all applicants before setting up an interview.

#### INTERVIEW:

HR staff stated that background checks are done annually on current staff during their birth month. They advised these checks are also done annually on all contract staff and volunteers. (Examples of background checks were provided and viewed.) They also advised that asking potential employees about previous misconduct is a part of the application process. (Examples of the application were provided to the auditor.) The also stated that any requests for information involving former employees are faxed to Central Office for them to respond. The staff interviewed during the audit process was very knowledgeable.

#### RECOMMENDATION:

None

### Standard 115.18 Upgrades to facilities and technologies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has installed or updated video monitoring system, electronic surveillance system, or other monitoring technology since August 20, 2012.

**DOCUMENTATION REVIEW:**

PREA Annual Report Protocol "At least once a year, the facility must evaluate their need for additional cameras and monitoring systems."  
The last meeting occurred March 27, 2015

**INTERVIEW:**

The Warden advised that camera placement is reviewed every year to determine if more cameras are needed. This is also discussed when the Incident Review Team meets on substantiated PREA cases.

**RECOMMENDATION:**

None

**Standard 115.21 Evidence protocol and forensic medical examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC is responsible for conducting administrative and criminal sexual abuse investigations (including inmate-on-inmate sexual abuse or staff sexual misconduct). Investigations conducted at WRDCC follow a uniform evidence protocol. This protocol is also developmentally appropriate for youth.

Forensic medical exams are offered without financial cost to victims. All exams, where possible, are conducted by Sexual Assault Forensic Examiners or Sexual Assault Nurse Examiners. If they are not available qualified medical professionals conduct the exams.

Victim advocates are made available to all victims.

**DOCUMENTATION REVIEW:**

Auditor reviewed WRDCC's "Evidence Procedure Manual."

The following policies were also reviewed: D1-8.1 Investigation Unit Responsibilities and Actions, pages 1 – 12, 14- 16; D1-8.4 Administrative Inquiries; D1-8.8 Evidence Collection, Accountability and Disposal.

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (G) Health Services Care, pages 17 – 20, covers the services for the PREA Audit Report



victim. Section III (K) of the same policy, page 20, addresses Advocacy.

WRDCC has a contract with Heartland Regional Medical Center – West to conduct all SANE/SAFE's In the past 12 months, no exams have been performed.

WRDCC has a contract with YWCA to provide advocacy services. If an advocate is not available, Chaplains at the facility have been trained by the Missouri Coalition Against Domestic and Sexual Violence to be qualified staff advocates. (Auditor reviewed curriculum used to train Chaplains.) Facility also has established a PREA Advocate Availability Rotation Schedule.

#### INTERVIEW:

Staff interviewed was able to explain the facilities "Coordinated Response" to a sexual assault. Each staff stated they would secure the scene and wait for investigators to arrive.

#### RECOMMENDATION:

None

### Standard 115.22 Policies to ensure referrals of allegations for investigations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The agency ensures that administrative or criminal investigations are completed on all allegations of sexual abuse and sexual harassment. All allegations of sexual abuse or sexual harassment are referred to the Inspector General for review. They determine if a criminal investigation is to be opened. If they do not open a criminal investigation, the warden then refers the case for administrative investigation.

#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (H) Investigations, page 20-21, states, "The department shall ensure that an administrative and/or criminal investigation is completed for all allegations of sexual abuse and sexual harassment and all referrals for such allegations shall be documented in accordance with the coordinated response to offender sexual abuse located on the department's intranet website..."

See also policy D1-8.5 Administrative Inquiries and D1-8.1 Investigation Unit Responsibilities and Actions.

WRDCC provided examples of their coordinated response as well as several investigations, one of which was referred for prosecution. An example of the tracking form used by the facility was also provided.

Policy D1-8.13 Offender Sexual Abuse and Harassment can be found on MDOC website at <http://doc.mo.gov/OD/PREA/php>

#### RECOMMENDATION:

None

### Standard 115.31 Employee training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC trains all employees who have contact with inmates on the 10 elements identified in this standard.

#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (B) (4), page 8, covers training requirements for new staff, current staff, part-time employees, volunteers, contract staff members and vendors. "All staff members shall receive initial PREA training during the department's basic training. All staff members shall complete refresher training every two years to ensure knowledge of the agency's current sexual abuse and sexual harassment procedures."

Auditor reviewed the following curriculum: Basic Training, dated November 2013; and PREA 2014 Refresher Training. Training logs were also reviewed. From November 2012 -- October 2015, 525 participants were trained in PREA 101 and 528 participants received the 2014 refresher training.

Policy D2-2.13 Transfer of Employees (E), page 6, covers training requirements for staff that transfer between facilities.

Auditor reviewed acknowledgement forms from staff, volunteers and contractors.

Auditor was also advised, "The department utilizes several avenues to ensure staff are kept informed about sexual abuse policies and practices between trainings. The department's policy and procedure unit is responsible for forwarding all new and revised policies to all staff. MDOC ensures the PREA intranet page is kept up to date. This page is readily available to all staff and contains all things PREA." (Auditor was provided an example of what this page looks like.)

#### INTERVIEW:

Staff interviewed remembered their PREA training and discussed the refresher training they received in the past year. Upon further questioning, staff was able to explain the facilities zero tolerance policy, their responsibility in preventing, detecting, reporting and responding to sexual abuse and harassment, the dynamics of sexual abuse in a confinement setting, etc. Staff also reported the Warden was involved in their PREA training and reiterated the importance of a zero-tolerance culture.

#### RECOMMENDATION:

None

### Standard 115.32 Volunteer and contractor training

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All volunteers and contractors who have contact with inmates have been trained on their responsibilities under the agency's policies and procedures regarding sexual abuse/harassment prevention, detection, and response.

DOCUMENTATION REVIEW:

Auditor reviewed the following curriculums: "Offender Work Release Procedure Training", dated March 2013, PREA components can be found on pages 11 -20; "Volunteers in Corrections," dated December 2011, PREA components can be found on pages 11 – 14.

Training logs and sample of acknowledgements were also viewed by this auditor.

RECOMMENDATION:

None

**Standard 115.33 Inmate education**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC provides information to inmates at the time of intake about the zero-tolerance policy and how to report incidents or suspicions of sexual abuse and harassment.

DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment Section III (C) 6, page 12, discusses Offender Education must be provided in the native language of the inmate and in formats that deaf, visually impaired or otherwise, can understand.

Memo from Director of Division of Adult Institutions, dated 4/11/2012 to all Wardens discussed PREA – Offender Education. This memo stated that "Speaking Up" video must be shown during formal orientation at all Reception and Diagnostic Facilities and again when they arrive at mainline facilities. They must also receive the PREA brochure "Offenders Sexual Abuse: What you need to know." (It should be noted this brochure was updated in August 2013. WRDCC provided documentation that all inmates received this updated brochure on 8/9/2013. Inmates were required to sign an acknowledgement.)

Auditor was provided examples of the R & D Orientation Packet, WRDCC General Population Orientation Packet, and Juvenile Unit Orientation Packet.

ONSITE:

Auditor toured the R & D Unit of WRDCC and was taken through the intake process. Inmates view the video "Speaking Up" before leaving R & D. Orientation packets in various languages were also shown to the auditor.

INTERVIEW:

Intake staff stated that PREA information is provided to inmates the day they arrive at WRDCC.

When talking with inmates at WRDCC, most stated they watched the PREA video and received PREA information upon arrival. Some inmates stated that it was 1 -2 days after arrival.

RECOMMENDATION:

None

**Standard 115.34 Specialized training: Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC requires that investigators are trained in conducting sexual abuse investigations in confinement settings. Agency maintains documentation of such training.

DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (B) (5), page 8, states, "All new investigators and administrative inquiry officers (AIOs) or designee assigned to investigate sexual abuse allegations shall receive specialized PREA Training."

Auditor reviewed the curriculum "Investigating Offender Sexual Abuse in Confinement Settings," 36 hour course designed for Inspector General staff and Investigators. This curriculum was last revised September 24, 2012 and covered the following topics:

- Techniques for interviewing sexual abuse victims (Module 4 "Investigating Allegations of Sexual Abuse," pages 12 – 16)
- Proper use of Miranda and Garrity (Module 2 "State Laws and Policies" pages 22 – 26)
- Criteria and evidence required to substantiate a case for administrative or prosecution referral (Module 4 "Investigating Allegations of Sexual Abuse" page 8 -11 and pages 18 -30)

This training curriculum also included a module titled "Mock Crime Scene Investigations" wherein participants took what they learned in previous modules and applied it a practice setting.

The auditor reviewed training logs and found that 56 investigators have been trained. The Investigators also signed acknowledgments stating they received and understood this training. While onsite, the auditor reviewed samples of these signed acknowledgments.

INTERVIEW:

Investigator was able to articulate what they received in this training and the basis PREA training that all staff received.

RECOMMENDATION:

None

### Standard 115.35 Specialized training: Medical and mental health care

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has a policy related to training of medical and mental health practioners who work regularly on its grounds. They do not provide forensic examinations.

#### DOCUMENTATION REVIEW:

Policy DI-8.13 Offender Sexual Abuse and Harassment, Section III (B) page 9, states, "Medical and mental health staff members shall receive annual specialized PREA training."

Auditor reviewed curriculum "PREA Specialized Medical/Mental Health Professionals" dated September 2012. This course is worth four hours and covers the following topics:

- How to detect and assess signs of sexual abuse and sexual harassment (pages 17 – 19)
- How to preserve and physical evidence of sexual abuse (pages 20 -22)
- How to respond effectively and professionally to victims of sexual abuse (page 23)
- How to and whom to report allegations and suspicions (page 15 – also addresses mandated reporting)

During this training, participants also viewed an eleven minute film titled "Maintaining Professional Relationships with Offender." After viewing this film, participants were required to sign an acknowledgement form stating they viewed and understood the film.

Auditor reviewed training rosters indicating that 31 mental health employees were trained in November 2014 along 65 medical personal. The auditor viewed a random sample of eight participants and found the corresponding signed acknowledgements.

#### INTERVIEW:

Medical/Mental Health Staff states that training is provided to staff every November on PREA and is well received. Staff interviewed articulated what was provided in training and were able to discuss their responsibility as mandated reporters.

#### RECOMMENDATION:

None

### Standard 115.41 Screening for risk of victimization and abusiveness

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion**

**must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has policy that addresses risk assessment screening upon admission to their facility as well as addresses reassessment requirements.

#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (C), pages 10 -11, states "Facilities shall assess offenders for the risk of being sexually abused and the risk of being sexually abusive utilizing their divisional adult internal risk assessment in accordance with the institutional services procedure...Offenders shall be assessed within 72 hours of arrival. Offenders shall be reassessed within 30 days of arrival."

Policy D1-8.13, Offender Sexual Abuse and Harassment, Section III (C)(1), pages 10, states "The offenders risk level shall be reassessed when warranted due to referral, incident of sexual abuse, or upon request or receipt of additional information that impacts an offenders risk of sexual victimization or abusiveness."

The time frame for administering the Internal Risk Assessment is also found in IS & SOP version of 5-2.3, Offender Internal Classification. On page 3, Section C (1), states, "Once an offender is received at the reception and diagnostic center, staff members will have seventy-two hours to complete an internal classification. In this same policy on page 4 in Section D (2) states, "CCM's will conduct a new internal classification within 72 hours at that facility and the offender will be housed in accordance with their new internal classification score."

Also on page 4 of this same policy in Section D (3) it states, "A second internal classification will be completed within thirty calendar days of the offender's arrival at the reception and diagnostic center, if they have not been transferred. If there is a change in the offender's internal classification score a case manager will review the offender's housing assignment to determine if a change in bed assignment is required. If an assignment change is required, this must be made on the same day the internal classification is completed. Any time an offender is returned to a diagnostic center this process will be repeated."

On pages 4 and 5 of this same policy, the facility outlines how the internal classification scores will be documented. In Section (F) it states, "(1) Upon completion of the internal classification process, a printout of the results will be placed in the offender's classification file in accordance with institutional services procedures regarding classification files and will be maintained in accordance with the departmental procedure regarding record retention. (2) CCMs will enter the offender's internal classification score into the department computer system along with the date of internal classification and their employee identification number in accordance with the internal classification manual."

Auditor reviewed WRDCC's risk screening tool and found all 10 elements in this standard were covered. Auditor also reviewed examples of assessments that were completed within 72 hours of intake and examples of reassessments at 30 days and those that were even driven.

Auditor also reviewed the "The Adult Internal Risk Assessment Manual" which contained relevant information on how to complete the internal risk assessment. For example this manual contained information found in agency policy for example information on reassessment requirements can be found on page 8 and on page 9 a user can find information on how to interview an offender to obtain the information necessary to accurately completing the assessment. The manual was well laid out, provided explicit instructions on how to score the assessment and included screen prints on how to enter the assessment into the facility's database.

#### ONSITE

While onsite the auditor reviewed a report of all assessments completed at WRDCC between October 1, 2014 and September 30, 2015. Five random initial assessments were selected and all met the 72 hour timeframe for completion. Five random 30 day assessments were also reviewed and all found to be completed within the required time frame. The auditor also reviewed five event driven reassessments. All assessments that were reviewed were completed according to PREA standards as well as agency policy.

#### INTERVIEWS:

Intake staff advised that the risk assessment tool is given to all arrivals within 72 hours, unless they sign the refuse to participate form. Intake staff also report that these inmates are also reassessed at the 30 day mark to see if any changes have occurred. (Auditor did reviewed an example of "Refusal to Participate" form that inmates can sign if the refuse to participate in the risk assessment. Inmates are also told that no sanctions will be given for refusal to participate.)

The Site Coordinator reported that all staff has access to the raw scores of the assessment which is then used to determining housing, programs and jobs. Staff is not given access to the direct responses to the questions. (There is limited access to the answers.)

Inmates that were interviewed could not remember exactly when this assessment was done but every one stated that it had been done and they "think" it was done at intake. Many referred to it as a "survey."

#### RECOMMENDATION:

None

#### Standard 115.42 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC uses the information from the risk screening required by 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive. Each determination is based on the individual. WRDCC has three classifications: Sigma, Alpha and Kappa.

Housing and program assignments for transgender or intersex inmates in the facility are made on a case by case basis.

WRDCC also has a transgender committee that meets regularly. This meeting consists of administrative staff, medical/mental health professionals, and the inmate to discuss the needs, housing, shower, and safety issues of the individual.

#### DOCUMENTATION REVIEW:

Policy IS5-2.3 Offender Internal Classification, Section III (C) Diagnostic Centers, page 3, addresses housing based internal classification. It states, "Upon completion of the internal classification, the offender will be housed according to his score in accordance to the internal classification manual. Whenever possible, sigmas should be celled with sigmas and alphas with alphas. If an offender does not have an internal classification score he should be housed with a kappa with similar demographics until the offender internal classification instrument is completed."

IS & SOP 18-1.1, Required Activities, page 5, Section III (B) (4), states, "Housing unit staff members will utilize the internal classification information to designate required activities assignments for the purpose of keeping separate and/or ensuring the appropriate monitoring of those offenders at high risk of being sexually victimized from those at high risk of being sexually abusive when working or attending programming together in accordance with institutional services procedures regarding offender internal classification. Housing unit staff members will review internal classification information and forward it to the required activities' supervisor prior to the offender's start date at the required activity."

On page 6 of this same policy, states, "The Required Activities Coordinator will notify the work supervisor of the offender's internal classification information. The work supervisor is responsible for knowing the internal classification of their workers and assign tasks in such a manner to ensure the appropriate monitoring of those offenders at high risk of being sexually victimized from those at high risk of being sexually abusive when working. Internal classification information shall not be used by any staff member to preclude placement of an offender in a required activity."

SOP D1-8.13 Offender Sexual Abuse and Harassment, page 12, "All housing, cell, bed, education, and programming assignments for transgender or intersex offenders shall be made in accordance with the institutional services procedures regarding offender housing assignments and programming assignments."

An example of housing bed assignments was provided via a memo dated October 9, 2015, "PREA Bed Assignments for all Housing Units."



This memo outlined which beds were to be used for housing Alpha or Sigma in compliance with PREA regulations. It also outlined that Kappa offenders may be housed with Alpha, Kappa or Sigma. It went on to outline which programs rooms were designated as Sigma Room or Alpha Room.

IS & SOP 5-1.1 Diagnostic Center Reception and Orientation, page 11 states, "If the gender of an offender is unknown, the following steps should occur: Speak with the offender privately to determine sex, review medical records, within 72 hours of receiving the offender into the department, a referral should be made to the transgender committee to assist in gender identity and housing determinations, offenders awaiting review by the transgender committee shall be placed in a single cell to ensure safety until the review has been completed."

On page 12 of this same policy, it states "Transgender offenders will be showered separately from other offenders until the recommendation of the transgendered committee is approved."

SOP D1-8.13, Offender Sexual Abuse and Harassment, page 11, states "Housing assignment for transgender and intersex offenders shall be made on a case-by-case basis by the institutional transgender/intersex committee or designee of the community confinement facilities to ensure the health and safety of the offender in accordance with the institutional services procedure regarding offender housing assignments and the probation and parole procedure regarding risk assessment and housing assignments."

IS & SOP 5-3.1 Offender Housing Assignments, pages 4 -5 addresses Transgender Housing Assignments. It also states, "The transgender committee is responsible for determining a permanent housing assignment for each transgender or intersex offender, and prior to this assignment shall meeting with each offender to determine his vulnerability within the general population and length of time living as the acquired gender."

WRDCC provided meeting minutes for six meetings of the Transgender Committee.

#### INTERVIEW:

Site Coordinator stated that information from the assessment tool is used to determine housing, education and programs. They also stated that the transgender committee meets regularly on each case and take the inmate's perception of safety into consideration. Meetings are always documented. They also stated that it is required that anyone identified at LGBTI needs to be assessed every 6 months.

When interviewing transgender inmates, they were complimentary of staff. They advised that staff inquires as to their safety and that they have not been housed separately from general population solely on their identification/status. They also report being included when the Transgender Committee meets to discuss their situation.

#### RECOMMENDATION:

None

#### Standard 115.43 Protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has policy that prohibits the placement of inmates at high risk for sexual victimization in involuntary segregated housing unless an assessment of all available alternatives has been made and a determination has been made that there is no available alternative means of separation from likely abusers. In the past 12 months, there has been no inmate placed in involuntary segregation.

#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, (F) Segregated Housing in Institutional Setting, pages 17 -18 states "Following an PREA Audit Report

allegation of offender sexual abuse or if an offender is assessed at being high risk of victimization, the shift commander shall ensure the offender is housed in the least restrictive housing available to ensure safety. The assessment for least restrictive housing shall occur within 24 hours of the allegation or the offender being identified as at risk. Least restrictive options to ensure safety of the offender and the security of the institution include:

- (1) Return to assigned housing.
- (2) Temporary reassignment of staff members.
- (3) Assignment to another housing unit.
- (4) Temporary segregated housing for protective custody needs (segregated housing should not be considered as the first option to ensure safety of the victim).

The assessment shall consider the allegation or threat and the safety of the victim and institution. If the assessment is due to an alleged PREA event the shift commander shall note on the PREA allegation notification penetration/non-penetration event checklist of the recommended housing option. If temporary segregation is recommended, the shift commander shall note on the PREA notification checklist the reason no alternative means of housing separation can be arranged and the offender victim shall be placed in segregated housing in accordance with institutional services procedures regarding segregation units. The shift commander shall ensure the alleged victims and perpetrators are separated by sight and sound while housed in a segregation unit. Offenders who are victims and/or perpetrators in an alleged PREA event will be kept out of sight and sound from each other and be placed in separate wings. If the assessment is due to an offender being viewed as being in substantial risk of victimization in the absence of an allegation of offender sexual abuse, and temporary administrative segregation confinement (TASC) is recommended to ensure the offender's safety, the shift commander shall note the PREA risk on the TASC order and the offender shall be placed in segregated housing in accordance with institutional services procedures regarding segregation units. The PREA site coordinator shall review all PREA notification checklists the following business day to ensure appropriate housing placement. Assignment to involuntary segregation housing shall not ordinarily exceed a period of 30 days. Every 30 days, the offender shall be afforded a review to determine whether there is a continuing need for separation from the general population in accordance with institutional services procedures regarding segregation units and protective custody."

Auditor reviewed memo dated October 19, 2015 addressing Involuntary Segregated Housing Assignments. It states, "Alleged victims of offender abuse or offenders viewed as being at risk of victimization should not typically be assigned to Administrative Segregation for Protective Custody for longer than a 30 day period. When an offender is assigned to administrative segregation for protective custody, the committee will: Review the offenders placement in segregated housing every 30 days to determine whether there is a continuing need for separation from general population and document the following on the classification hearing form: the basis for the facility's concern for the offender's safety, the reason no alternative means of separation can be arranged, and, work and programming assignments that the victim was participating in that they are now unable to attend due to Administrative Segregation assignment."

Auditor reviewed MDOC's Segregated Housing for Protective Custody which outlines the an assessment of all alternative housing choices (least restrictive housing) must be conducted prior to placing a victim in segregated housing for protection and that victims of sexual abuse ordinarily not be held in segregated housing for longer than 30 days.

#### ONSITE:

On the day of the audit there were no inmates being held in segregation based on high risk for victimization. The auditor did review five PREA allegation notifications that have been completed in the past 12 months. In looking at the housing placement recommendations, all indicated that alleged victim would remain in the original housing units. Only alleged perpetrators were removed.

WRDCC did provide an example of what a classification hearing and documentation would like if a victim would be placed in protective custody and an example of the "PREA Ad-Seg Checklist."

#### INTERVIEW:

Staff reported that the typical response is not to segregate the victim. They stated if involuntary segregation would be used to protect a victim, they would follow agency policy. They reported it is not to be longer than 48 hours and they do their best to make sure programming would continue. Staff reported that everything is documented and becomes a part of the classification hearing that is held.

Staff that works in the segregation unit stated they could not remember the last time an inmate was housed in protective custody due to a PREA incident.

An inmate that reported sexual abuse was selected to be interviewed. However, he declined to participate in the audit process.

## RECOMMENDATION:

None

### Standard 115.51 Inmate reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has established multiple procedures for allowing inmates internal ways to report sexual abuse or sexual harassment privately to the facility or to an outside entity. Inmates may report via an informal resolution request, to a staff member, PREA hotline, advocacy agency, or to the Department of Public Safety, Crimes Victims Services Unit. Third party reports are also accepted by WRDCC.

As of the date of this audit, WRDCC does not have any offenders who are detained solely for civil immigration purposes.

## DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, "Reporting Sexual Abuse or Harassment," pages 14 states, "Each facility CAO's or designee shall provide multiple ways for offenders to make anonymous reports of allegations of offender sexual abuse and harassment, retaliation, staff neglect, and violation or responsibilities that may contributed to an incident of offender sexual abuse , to include but not be limited to: informal resolution request (IRR), grievance process, or offender complaint, to a staff member, PREA hotline, advocacy agency, and Department of Public Safety, Crimes Victims Services Unit."

Auditor reviewed the MOU with the Missouri Department of Public Safety. Missouri Department of Public Safety's responsibilities include initiating a SharePoint application that can be shared by DPS and DOC. The DPS shall receive written correspondence of allegations of offender sexual abuse and harassment. All written correspondence received by the DPS shall be assigned a tracking number. The DPS shall record in the SharePoint application the date of the written correspondence is received, the name of the institution, the name of the victim if known and the date the letter is forwarded to the DOC. The DOC shall record in the SharePoint application the date offender letter is received and any action taken. This MOU is ongoing from the date of the final signature until such time as it is deemed unnecessary by either party. The MOU was signed July 25, 2013.

SOPD1-8.13, Offender Sexual Abuse and Harassment, page 14, states, "All allegations including anonymous, third party, verbal, or allegations made in writing shall be accepted and moved forward in accordance with the offender sexual abuse coordinated response outlined in this procedure."

Auditor reviewed the "Western Reception Diagnostic and Correctional Center Receiving & Diagnostic Unit Orientation Packet, revised 10/09/2015. PREA is covered on pages 19 – 21. On page 20, inmates can find several ways to report sexual abuse and harassment. It outlines ways an inmate can make a report anonymously, using the PREA Hotline or Crime Tips Hotline, as well as writing to the Department of Public Safety, Just Detention International and Rape, Abuse, and Incest National Network.

Policy D1-8.9 Crime Tips and PREA Hotlines, page 5, Section III (C) states, "For staff, the department has established a separate crime tips hotline to anonymously report criminal activity, offender sexual abuse, or offender sexual harassment and is received in the office of inspector general. These calls may be answered by a staff member in the office of inspector general or in cases of afterhours calls, the caller may leave a message and a return phone number should they wish to be contacted. Information regarding hotline use for staff will be posted conspicuously in areas routinely accessible to all staff members."

## ONSITE:

Information was posted on bulletin boards throughout the facility and in the housing units advising inmates on how to make reports of sexual

abuse. The PREA hotline number was clearly posted above all phones.

Staff Tips Hotline posters are throughout the facility and are located in staff break rooms and on the MDOC intranet home.

Auditor also reviewed the following orientation packets:

- Housing Unit 1
- Receiving & Diagnostic Unit
- General Population

Each of these orientation packets includes information on reporting sexual abuse. It outlines the many ways inmates can report abuse and harassment. This includes:

- telling or write any staff member, volunteer or contract staff
- calling the PREA or Crime Tips Hotline
- anonymous procedure
- reporting while in administrative segregation
- reporting while in general population and treatment
- addresses for Department of Public Safety and Just Detention International, and Rape, Abuse, and Incest National Network (RAINN)

#### INTERVIEW:

Staff was able to articulate the various ways inmates can report sexual abuse and sexual harassment. They stated that all reports are taken seriously. They also advised that they could also call the PREA hotline and make a report.

Inmates interviewed were also able to articulate the various ways they could make a report including calling the hotline, telling staff and/or family members. Although they were aware of the PREA hotline, many felt that it was not anonymous.

#### RECOMMENDATION:

None

#### Standard 115.52 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has an administrative procedure for dealing with inmates grievances regarding sexual abuse. This procedure also allows them to submit a grievance at any time regardless when the incident occurred. If their grievance is against a staff member they are not required to submit their grievance through that staff member. WRDCC also outlines, through policy, where grievance cannot be filed.

WRDCC also requires that a decision on the merits of any grievance or portion of a grievance alleging sexual abuse be made within 70 days of the filing of the grievance. According the pre-audit questionnaire, the agency reported that in the past twelve months, only 2 such grievances have been filed.

## **DOCUMENTATION REVIEW:**

Policy D1-8.13 Offender Sexual Abuse and Harassment, Page 13 - 14, states "The department shall not require an offender to use any informal grievance or complaint process, or to otherwise attempt to resolve with staff members, an alleged incident of sexual abuse...nor impose a time limit"

Policy D1-8.9 Crime Tips and PREA Hotlines, page 4, Section III (A)(1a) states "The hotlines will not be utilized for complaints, grievances or other unrelated purposes."

Policy D5-3.2 Offender Grievance, pages 17-19 addresses PREA Informal Resolution Request, Grievance and Appeal. The following are portions of this policy that supports this standard:

### **Time limit**

- "The department shall not impose a time limit on when an offender may submit a complaint regarding an allegation of offenders' sexual abuse."

### **Informal Process**

- "The department will not require an offender to use the informal grievances process, or to otherwise attempt to resolve with staff members, an alleged incident of offender sexual abuse."
- "Informal resolution request alleging sexual abuse will be processed normally with the exception of the following: A response should be completed as soon as practical, but no later than 30 calendar days of receipt."

### **Against a Staff Member**

- "A staff member who is subject of the complaint should not be the respondent."

### **Grievance Process**

- "Offender grievances alleging sexual abuse will be processed normally with the following exceptions: the CAO or designee should respond within 30 calendar days of receipt, and, computation of the 30 day time period will not include the days between the offender's receipt of the informal resolution request and receipt of the offender grievance by the grievance officer or designee."
- "Offender grievance appeals alleging offender sexual abuse will be processed normally with the following exceptions: a response should be provided as soon as practical, but no later than 30 calendar days of receipt, and, computation of the 30 day time period will not include the days between the offender's receipt of the offender grievance response and receipt of the offender grievance appeal by central office grievance staff members. Appeals will be referred to the deputy division director or designee, and, an extension of time to respond, of up to 70 days, may be claimed if the normal time period for response is insufficient to make an appropriate decision. The offender will be notified in writing of any such extension and will be provided a date by which a response will be provided."
- "At any level of the administrative process, including the offender grievance appeal level, if the offender does not receive a response within the time allotted for reply, including any properly noticed extension, the offender may proceed to the next level of the offender grievance process"

### **Third Party Reporting:**

- "Third parties, including fellow offenders, staff members, family members, attorneys, and outside advocates, shall be permitted to assist offenders in filing requests for informal resolution requests, grievances or appeals relating to allegations of offender sexual abuse. This assistance cannot interfere with the safety and security of the institution."
- "When a staff member receives a request from a third party to file a complaint via the offender grievance procedure on behalf of an offender regarding allegations of offender sexual abuse. The staff member will require the party making the complaint to submit such in writing."
- "Administrative or case management staff members will then prepare a report of incident in accordance with procedure for possible investigation or inquiry."
- "When a staff member receives the documentation from the reporting third party, it will be attached to an informal resolution request form and will immediately be recorded in accordance with this procedure. A copy of the documentation will also be forwarded to the CAO or designee in order to be attached to the possible investigation or inquiry."
- "The case manager shall attempt to discuss the issue with the offender (victim) prior to developing a response to confirm if the alleged victim agrees to have the request filed on his behalf."

- "If the offender declines to have the request process on his behalf, the case manager shall document the offender's decision in the discussion section of the informal resolution request form and the complaint shall be considered withdrawn for grievance purposes."
- "If the offender agrees to have the request processed on his behalf, it will then be documented in the discussion section of the informal resolution request and will be processed normally in accordance with this procedure."

#### **Emergency Informal Resolution Requests**

- "Allegations of offender sexual abuse by employees shall immediately be reported to the CAO or designee for possible investigation or inquiry."
- "If the staff member who processes the informal resolution requests determines that it meets the definition of a PREA emergency complaint, the offender will be provided an informal resolution request form."
- "Emergency informal resolution requests will be processed as follows:
  - The offender will request an informal resolution request form from case management staff members and briefly state the issues and subject of complaint in accordance with this procedure.
  - When a staff member receives the completed informal resolution request form from the offender, the staff member will record receipt of the form in accordance with this procedure and it will be taken to the CAO or designee immediately.
  - Upon receipt of an informal resolution request from an offender, the CAO or designee may confer with the PREA site coordinator to make the determination if the informal resolution request should be handled as an emergency.
  - The CAO or designee will prepare an initial response which will be attached to the informal resolution request and provided to the offender within 48 hours of receipt of the initial filing date. The offender will sign and date the response.
  - A final response from the CAO or designee will be provided to the offender within 5 calendar days from the initial filing date. The offender will sign and date the form.
  - The initial and final response for the informal resolution request shall document the department's determination whether the offender is in substantial risk of imminent sexual abuse and the action taken in response to the emergency informal resolution request.
  - If the offender is unsatisfied with the final response for the informal resolution request and chooses to file a grievance, an offender grievance form will be provided. The grievance or grievance appeal will then be processed as a non-emergency PREA complaint as noted in this procedure."

SOPDI-8.13 Offender Sexual Abuse and Harassment, page 14, addresses exhausting administrative remedies. It states, "The department shall not require an offender to use any informal grievance or complaint process, or to otherwise attempt to resolve with staff members, an alleged incident of sexual abuse. The department shall not impose a time limit on when an offender may submit a grievance or complaint regarding an allegation of sexual abuse. The department may apply otherwise applicable time limits to any portion of a grievance or complaint that does not allege an incident of sexual abuse in accordance with the department procedure regarding offender grievance, administrative inquiries, and investigation unit responsibilities and actions. The department shall ensure that an offender who alleges sexual abuse may submit a complaint to a staff member who is not the subject of the complaint and the grievance or complaint is not referred to a staff member who is the subject of the complaint. Staff members are to address grievances or complaints for allegations of sexual abuse and harassment in accordance with the department procedure regarding offender grievance, administrative inquiries, and investigation unit responsibilities and actions."

Memo dated January 29, 2014, "PREA Grievance Protocol," states, "Effective immediately, offender sexual abuse allegations received via the IRR/Grievance system will be processed as outlined in the attached flow chart; however, there will be no change in the process used for IRRs/Grievances alleging offender sexual harassment. The changes mandated by PREA are not significant and will not cause an undue workload issue. In addition, it is imperative that you track the IRR/Grievance responses as will be outlined in your meeting today." Two flow charts were also reviewed: Offender Grievance and Offender PREA Grievance for Sexual Abuse. A copy of the presentation made at this meeting titled "PREA & the Grievance Process" was also reviewed.

Policy D5-3.2 Offender Grievance, page 6, Section III, (E)(2b)(1) states, "Upon approval of the division director or designee, a conduct violation may be issued for threats. This conduct violation will not be viewed as retaliation reprisal." Also on page 6, Section III (E)(4a)(1) it states, "When there is evidence to support an unfounded allegation, the CAO or designee will issue a conduct violation and the CAO or designee will issue a letter of limited filing status."

ONSITE:

WRDCC reports they have had no third party grievances filed within the past year.

WRDCC provided a Grievance Tracking Log which tracks the month the grievance was filed, the type of grievance, the name of the offender, date received, 70 day extension, date completed, calendar days, declined 3<sup>rd</sup> party assistance, alleged substantial risk of imminent sexual abuse, move forward with PREA Emergency IRR, Emergency Initial Response within 48 hours, Emergency Final Response within 5

days, and disciplinary action taken against offender for filing grievance in bad faith. This log had four grievances listed: one dated in 2014 and three in 2015. Examples of these grievances were pulled from WRDCC database and corresponded with the Grievance Tracking Log. All grievances listed on this log were under the 70 day timeframe.

WRDCC reports they have had no emergency grievances filed pursuant to this standard.

INTERVIEW:

The inmate at the facility that reported sexual abuse refused to participate in this interview.

RECOMMENDATION:

None

**Standard 115.53 Inmate access to outside confidential support services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC provides inmates with outside access to victim advocates for emotional support services related to sexual abuse. They also inform inmates prior to given them access to outside supports, the extent to which such communications will be monitored. WRDCC maintains a MOU with the YWCA to provide advocates.

DOCUMENTATION REVIEW:

SOP version D1-8.13 Offender Sexual Abuse and Harassment, pages 20 -21 covers the procedure during the initial assessment with mental health when there is an allegation of sexual abuse and harassment. It states, "During the initial assessment, mental health treatment interventions will be discussed with the victim by QMHP and will include options such as individual and/or group therapy. The QMHP will explain and offer advocacy services to the alleged victim offender. Advocacy will not be offered for allegations of sexual harassment. The QMHP will document the offender's acceptance or refusal of advocacy services in the electronic medical record. If the offender refuses advocacy services the QMHP will have the victim sign the refusal or treatment/no show form. A copy of the refusal of treatment form will be forwarded to the PREA site coordinator to be placed in the PREA event file. If the offender requests an advocate, the QMHP will notify the site advocacy liaison. QMHP will notify the PREA site coordinator in writing or email when victim requests an advocate. PREA site coordinator will subsequently notify the investigative staff of victim's request for advocate. When the victim is out counted to MOSAIC Life Care for a SANE exam the hospital will contact the YWCA for advocacy services. When advocacy hours provided by the YWCA have been exhausted, the PREA site coordinator will notify the chaplain of the victim's request for an advocate. Institutional chaplain will meet with the victim and document the meeting, forwarding this documentation to the PREA site coordinator to be placed in the PREA event file."

Auditor reviewed the MOU with YWCA. This MOU is ongoing and outlines the confidentiality exceptions.

Auditor reviewed the "Consent for Facility Advocacy Services" if an advocate from the YWCA is not available. This consent form also outlines the confidentiality exceptions.

ONSITE:

Advocacy information is listed on bulletin boards in the each housing units. They are clearly marked "Advocates." A brochure on "YWCA PREA Advocacy Services" is also available to inmates at WRDCC and was viewed by the auditor.



Auditor also reviewed the following orientation packets:

- Housing Unit 1
- Receiving & Diagnostic Unit
- General Population

Each orientation packet contained a section titled "Guide to Advocacy Services." This section lets inmates know that advocacy services are available for offenders who allege sexual abuse or sexual harassment and how to request those services. It goes on to explain what an advocate does and their (the offender victim) right to confidentiality.

INTERVIEW:

Interviews with inmates resulted in mixed responses in when it came to the discussing availability of advocates. Most stated they knew they were available but was unsure how to access them if needed.

RECOMMENDATION:

None

**Standard 115.54 Third-party reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC provides a method to receive third party reports of inmate sexual abuse or sexual harassment. Family members can make report via information found on MDOC website. They can either email or make a phone call.

DOCUMENTATION REVIEW:

Policy SOPD1-8.13 Offender Sexual Abuse and Harassment, Section III (D)(2), page 14 states, "All allegation including anonymous, third party, verbal, or allegations made in writing shall be accepted and moved forward in accordance with the offender sexual abuse coordinated response outlines in this procedure."

Auditor verified that reporting information is on the MDOC website. The URL is <http://doc.mo.doc/OD/PREA.php>. This site has an email address and a phone number available to the public.

RECOMMENDATION:

None

**Standard 115.61 Staff and agency reporting duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC requires all staff to report immediately any knowledge or suspicion of any incident of sexual abuse or sexual harassment. This is also in their policy.

#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment, page 7, "The CAO or designee shall control the dissemination of sensitive information related to offender sexual abuse to ensure the offender is not exploited by staff members or other offenders. Failure to report offender sexual abuse is a class A misdemeanor. All staff members, volunteers, and contractors shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility and any knowledge of retaliation against offenders or staff members who reported such an incident and any staff member neglect or violation of responsibilities that may have contributed to an incident or retaliation in accordance with this procedure. Medical and mental health staff members shall inform offenders of the practitioner's duty to report at the initiation of services. Staff members are prohibited from revealing any information related to an allegation of offender sexual abuse or harassment other than to the extent necessary to make treatment, investigation, and other security and management decisions."

Policy IS11-32 Receiving Screening Intake Unit, page 5 addresses procedure if the alleged victim is under the age 18 or considered to be a vulnerable adult. The policy states, "Health services staff members shall obtain informed consent from offenders in accordance with institutional services regarding informed consent before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18. If the offender is under the age of 18, a health service staff member shall report the allegation to the designated local Children's Division, Department of Social Services under applicable mandatory reporting laws."

Auditor also reviewed Missouri Revised Statutes, Chapter 217, Department of Corrections, Section 217.410. 1 which states, "When any employee of the department has reasonable cause to believe that an offender in a correctional center operated or funded by the department has been abused, he shall immediately report it in writing to the director."

Missouri Revised Statutes, Chapter 630, Department of Mental Health, Section 630.005.1, defines a vulnerable person as "any person in the custody, care, or control of the department that is receiving services from an operated, funded, licensed, or certified program."

Missouri Revised Statutes, Chapter 630, Department of Mental Health, Section 630.163.1, defines mandatory reporting requirements as "Any person having reasonable cause to suspect that a vulnerable person presents a likelihood of suffering serious physical harm or is the victim of abuse or neglect shall report such information to the department. Reports of vulnerable person abuse received by the departments of health and senior services and social services shall be forwarded to the department."

Policy D2-11.10, Staff Member Conduct, not only states that staff members must obey all laws but on page 7, Section III, (D1&2) states, "Staff members having knowledge of any instances of offender or resident abuse or sexual contact with an offender or resident shall immediately report such to the inspector general in accordance with the department procedures regarding offender physical abuse and offender sexual abuse and harassment. Staff members must immediately report any misconduct through the appropriate chain of command. If there is reason to believe that any staff member in the chain of command may be involved in the alleged misconduct, the staff member should report the matter to the next higher level of management in the department."

SOPD1-8.13, Offender Sexual Abuse and Harassment," pages 16 and 17 states, "All allegations of offender sexual abuse and/or harassment, including third party and anonymous reports, shall immediately be forwarded to the shift supervisor to initiate the coordinated response utilizing the applicable PREA allegation notification penetration/non-penetration event checklist. The coordinated response will be completed and distributed as outlined in the Coordinated Response Completion Guide (SOP Reference E) as well as the Coordinated Response to Offender Sexual Abuse (Institutions) protocol (SOP Reference F). Offender/staff interpreters for non-English speaking victims/perpetrators can only be utilized in an exigent circumstance when the event is first reported until and outside interpreter can be arranged." WRDCC also provided a copy of their PREA Coordinated Response to Offender Sexual Abuse.

INTERVIEW:

Staff interviewed stated they were mandated reporters. They also reported that it is a crime if they don't report knowledge of sexual abuse or sexual harassment of inmates. They also stated that they are not allowed to discuss their knowledge of such incidents with anyone that is not a part of this investigation.

Staff also stated that all allegations are sent to the Inspector General and they determine whether to investigate the case or not.

RECOMMENDATION:

None

**Standard 115.62 Agency protection duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC acts immediately if they learn that an inmate is subject to a substantial risk of imminent sexual abuse. In the past twelve months there have been no inmates that have been reported to be subject to substantial risk of imminent sexual abuse.

DOCUMENTATION REVIEW:

SOPD1-8.13, Offender Sexual Abuse and Harassment, page 18, under Segregated Housing in Institutional Setting states, "If the assessment is due to an offender being viewed as being in substantial risk of victimization in the absence of an allegation of offender sexual abuse, and temporary administrative segregation confinement (TASC) is recommended to ensure the offender's safety, the shift commander shall note the PREA risk on the TASC order and the offender shall be placed in segregated housing in accordance with institutional services procedures regarding segregation units."

INTERVIEW:

Administrative staff stated that the expectation for all staff is to act immediately if they become aware of an offender being in imminent danger of sexual abuse. This involves beginning the facility's coordinate response and separate the victim from the alleged perpetrator.

Random staff reported that if such an incident would occur they would immediately secure the alleged victim for safety purposes and contact their supervisor.

RECOMMENDATION:

None

**Standard 115.63 Reporting to other confinement facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has a policy requiring that, upon receiving an allegation that an inmate was sexually abused while confined at another facility that the Warden must notify the head of the facility where the sexual abuse is alleged to have occurred. Notification is to be made as soon as possible but no later than 72 hours after receiving the allegation.

They also have a policy that states that allegations received from other facilities are investigated in accordance with PREA standards.

#### DOCUMENTATION REVIEW:

SOPD1-8.13 Offender Sexual Abuse and Harassment, page 17 states, "Upon receiving information that an offender has been sexually abused while assigned at another facility the coordinated response for offender sexual abuse will be immediately initiated as outlined in this procedure. If the alleged abuse occurred at a facility outside the Missouri Department of Corrections, the notification checklist will be forwarded to the department's PREA coordinator. The PREA coordinator will ensure notification to the facility is made within 72 hours. A coordinated response will be initiated as outlined in this procedure for all allegations of offender sexual abuse that are received from facilities outside the Missouri Department of Corrections."

#### ONSITE:

Auditor reviewed four records of notifications made to other state operated facilities in Missouri and three notifications made to county jails in Missouri. All notifications reviewed were made within the required 72 hour time frame after receiving the allegation.

WRDCC had one example of a notification from another facility. A PREA protocol was initiated.

Staff report that allegations received from another facility is immediately sent to the Site Coordinator who then sends it the Inspector General who determines if an investigation will be open.

#### INTERVIEW:

Interview with facility administration revealed that any notification WRDCC receives is sent to the site coordinator who then sends information to the Inspector General. Administration advises that the Inspector General will make the determination if an investigation will be opened.

#### RECOMMENDATION:

None

### Standard 115.64 Staff first responder duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has a Coordinator Response in policy that outlines the duties of a first responder. This coordinated response has all four components listed in this standard. WRDCC reported they had 13 allegations reported where security staff members responded to reported allegations where they victim and perpetrator had to be separated and evidence was collected. They also advised they had 18 allegations reported where a non-security staff was the first responder and secured potential evidence on the victim. They reported that in all of these allegations, security staff was notified in all eighteen instances.

#### DOCUMENTATION REVIEW:

Auditor reviewed WRDCC's Coordinated Response that is a part of policy D1-8.13 Offender Sexual Abuse and Harassment located on page 17. This part of the policy states, "Staff member first responder shall:

- Ensure the safety of the victim.
- Request the victim not to take any actions that may destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, when applicable.
- Make immediate notification to the shift commander or shift supervisor.
  - In the event of an allegation of a penetration act, the shift commander or shift supervisor shall make telephone notifications and respond as outlined in the divisions' coordinated response to offender sexual abuse protocol.
  - In the event of a non-penetration or harassment event the shift commander or shift supervisor shall make email notifications as outlined in the applicable PREA notification checklist protocol.
- Shift supervisors will copy the email notification with the PREA checklist attachment to necessary WRDCC mental health staff. Shift supervisors will complete and forward (via email and hard copy) the Referral and Screening Note-Health Services form to the mental health staff."

Auditor reviewed the lesson plan for PREA Basic Training, pages 21 –23 covers first responder responsibilities. It breaks down the First Responder responsibilities by type of event. The three events covered include: allegation of penetration that has happened within 72 hours, all other penetrations and allegations of non-penetration events.

#### ONSITE:

Auditor review documented examples of a coordinated response. This included reviewing notifications made by security staff and non-security staff. Each notification included date and time of incident, location of incident, name and custody information of victim as well as the alleged perpetrator. Notifications also included a description of the event, date and time of persons to be notified and recommendation for housing placement. If a forensic exam was required, location of the examination as well as date and time victim was sent out and then returned to the facility.

#### INTERVIEW:

Staff all stated that as a first responder they responsibility is to separate the victim from the abuser, allow neither one of them to shower, get a drink or change clothes. They stated they would then call their supervisor who, in turn, contacts the investigators. Staff would also secure the scene and would not allow anyone to enter until the investigators arrived and took control. When asked if they would let the Warden enter the scene, all but one staff said they would not. The one staff member who said they would let the warden enter the scene stated they would document that the warden entered the area.

#### RECOMMENDATION:

None

#### Standard 115.65 Coordinated response

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion**

**must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has developed a coordinated response to all sexual abuse incidents.

#### DOCUMENTATION REVIEW:

The coordinated response to offender sexual abuse covers the following topics:

- Role and Responsibilities of Shift Commander, Site PREA Coordinator, First Responder, Mental Health, and Medical
- Exceptions to the protocol

SOPD1-8.13 Offender Sexual Abuse and Harassment includes a section on coordinated response on pages 16 and 17. It states, "CAO or designee shall coordinate actions taken by first responders, medical, mental health, investigators, and administrators in response to all allegations of offender sexual abuse and harassment as outlined in the divisions' coordinated response to offender sexual abuse protocol. All allegations of offender sexual abuse and/or harassment, including third party and anonymous reports, shall immediately be forwarded to the shift supervisor to initiate the coordinated response utilizing the applicable PREA allegation notification penetration/non-penetration event checklist. The coordinated response will be completed and distributed as outlined in the Coordinated Response Completion Guide (SOP Reference E) as well as the Coordinated Response to Offender Sexual Abuse (Institutions) protocol (SOP Reference F). Offender/staff interpreters for non-English speaking victims/perpetrators can only be utilized in an exigent circumstance when the event is first reported until an outside interpreter can be arranged. If the allegation is reported directly to a facility administrator the administrator can initiate the coordinated response to ensure confidentiality utilizing the notification checklist.

Staff member first responder shall:

- Ensure the safety of the victim.
- Request the victim not to take any actions that may destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, when applicable.
- Make immediate notification to the shift commander or shift supervisor.
  - In the event of an allegation of a penetration act, the shift commander or shift supervisor shall make telephone notifications and respond as outlined in the divisions' coordinated response to offender sexual abuse protocol.
  - In the event of a non-penetration or harassment event the shift commander or shift supervisor shall make email notifications as outlined in the applicable PREA notification checklist protocol.
  - Shift supervisors will copy the email notification with the PREA checklist attachment to necessary WRDCC mental health staff. Shift supervisors will complete and forward (via email and hard copy) the Referral and Screening Note-Health Services form to the mental health staff.
- Upon receiving information that an offender has been sexually abused while assigned at another facility the coordinated response for offender sexual abuse will be immediately initiated as outlined in this procedure. If the alleged abuse occurred at a facility outside the Missouri Department of Corrections, the notification checklist will be forwarded to the department's PREA coordinator. The PREA coordinator will ensure notification to the facility is made with 72 hours.
- A coordinated response will be initiated as outlined in this procedure for all allegations of offender sexual abuse that are received from facilities outside the Missouri Department of Corrections."

PREA Coordinated Response Training was held on April 13, 2015. This training covered the PREA Coordinated Response Completion Guide. The included PREA definitions and step-by-step guide on how to complete the notification form. This guide specifically states that a staff first responder must separate the alleged victim and perpetrator and how to preserve evidence. The Coordinate Response is also reviewed.

#### INTERVIEW

Administrative staff articulated all of the components of the facility's coordinated response. The expectation outlined by the administration is that every employee should be knowledgeable of the coordinated response and execute the response when needed.

#### RECOMMENDATION:

None

### Standard 115.66 Preservation of ability to protect inmates from contact with abusers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

MDOC has a labor agreement with Missouri Corrections Officers Association that ends 9/30/2018.

#### DOCUMENTATION REVIEW:

Policy D2-11.6, Labor Organization, page 4 states, "Per the Prison Rape Elimination Act, the department shall not enter into or renew any collective bargaining agreements or other agreements that limit the department's ability to remove alleged staff sexual abusers from contact with any offender resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted."

On page 2, Article 2, Management Rights of Labor Agreement between the State of Missouri Office Administration, The Department of Corrections Division of Adult Institutions and Missouri Corrections Officers Association (MOCOA) states, "The right to hire, assign, reassign, transfer, promote and to determine hours of work and shifts and assign overtime."

#### RECOMMENDATION:

None

### Standard 115.67 Agency protection against retaliation

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has policy in place to protect all inmates and staff who report sexual abuse or sexual harassment or cooperate with sexual abuse or sexual harassment investigation from retaliation by other inmates or staff.

#### DOCUMENTATION REVIEW:

SOPD1-8.13 Offender Sexual Abuse and Harassment, pages 15 -16 outlines the protection from retaliation for inmates and staff in the following manner:

- Inmates:



- The PREA site coordinator shall ensure all victims and reporters and those that cooperate with offender sexual abuse and harassment investigations or inquiries are monitored and protected from retaliation.
- Immediately following any reported incident of sexual abuse or harassment, monitoring for retaliation shall be conducted in the following manner:
  - The alleged victim and reporter of offender sexual abuse or harassment shall be monitored for a minimum of 90 days to assess any potential risk or act of retaliation.
    - For offender victims and offender reporters, monitoring shall include face-to-face status checks by staff members a minimum of every 30 days.
    - The assessment/retaliation status check form shall be used during each of the assessment interviews.
    - If the victim or reporter expresses fear of retaliation, monitoring shall continue for an additional 90 day period or until the victim or reporter is no longer in fear of retaliation or if the investigation or inquiry is unfounded.
- Staff
  - The PREA site coordinator or designee shall monitor all staff reporters of offender sexual abuse or harassment for a minimum of 90 days. Monitoring shall include but is not limited to monitoring for changes that may indicate retaliation, negative performance reviews, or reassignments.
    - The assessment/retaliation status check form shall be used during each of the assessment interviews.
  - The PREA site coordinator or designee shall ensure all witnesses receive an initial assessment utilizing the assessment/retaliation status check form.
    - Witnesses who voice they have no concerns regarding potential retaliation shall not receive further monitoring.
    - The witness shall sign the assessment/retaliation status check form showing they have no concerns regarding potential retaliation.

This policy also states, "The PREA site coordinator shall report all evidence of retaliation to the CAO to ensure an inquiry or investigation is initiated in accordance with department procedures. If possible retaliation is suggested, the PREA site coordinator shall act promptly to remedy any such retaliation and protect the individual. The PREA site coordinator shall ensure victims, reporters, and witnesses that report a fear of retaliation and/or possible victims of retaliation be offered emotional support services. Emotional services for offender victim, reporters, or witnesses include but are not limited to, case management or referral to mental health, chaplain, or advocacy when appropriate. Emotional services for staff reporters or witnesses included but are not limited to, employee assistance program, peer action and care team referral, and/or chaplain referral. All action taken to remedy retaliation or services offered victim or suspected victim shall be noted on the assessment/retaliation status check form. In the event that a victim, offender reporter, or a witness is transferred during a period of monitoring, the PREA site coordinator shall forward the assessment/retaliation status check form to the PREA site coordinator in the receiving institution. The PREA site coordinator at the receiving institution shall ensure monitoring continues as outlined in this procedure. The PREA site coordinator shall ensure the completed assessment/retaliation status check form is returned to the originating institution to be filed in the PREA incident file for future audits. If released to a community confinement facility monitoring will continue. If released to a field probation and parole office, monitoring will stop. In the event the allegations are determined to be unfounded the agency shall terminate monitoring."

#### ONSITE:

WRDCC provided an example of "Assessment/Retaliation Status Checklist" form; also provided example of monitoring for retaliation. These four monitoring examples show check-ins averaging once every 30 days.

#### INTERVIEW:

Administration stated that the facility monitors for retaliation and that it is not tolerated. They reported that inmates who report allegations or cooperate with allegations are contacted to see if any types of retaliation from other inmates or staff is occurring. They want to let them know they take allegations seriously. Administration stated that contact should be made every 30 days for at least three months. If needed, monitoring can be extended beyond that time. Administration advised that this type of protection is also given to their employees, contractors and volunteers. It was stressed again that retaliation from anyone will not be tolerated.

#### RECOMMENDATION:

None

## Standard 115.68 Post-allegation protective custody

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has policy that prohibits the placement of inmates who allege to have suffered sexual abuse in involuntary segregated housing unless an assessment of all available alternatives has been made. In the past twelve months, there have been no inmates placed in involuntary segregated housing.

### DOCUMENTATION REVIEW:

SOPD1-8.13, Offender Sexual Abuse and Harassment, pages 17 and 18, under Segregated Housing in Institutional Setting states, "Following an allegation of offender sexual abuse or if an offender is assessed as being at high risk of victimization, the shift commander shall ensure the offender is housed in the least restrictive housing available to ensure safety. The assessment for least restrictive housing shall occur within 24 hours of the allegation or the offender being identified as at risk. Least restrictive options to ensure safety of the offender and the security of the institution include:

- Return to assigned housing.
- Temporary reassignment of staff members.
- Assignment to another housing unit.
- Temporary segregated housing for protective custody needs (segregated housing should not be considered as the first option to ensure safety of the victim).

The assessment shall consider the allegation or threat and the safety of the victim and institution. If the assessment is due to an alleged PREA event the shift commander shall note on the PREA allegation notification penetration/non-penetration event checklist of the recommended housing option. If temporary segregation is recommended, the shift commander shall note on the PREA notification checklist the reason no alternative means of housing separation can be arranged and the offender victim shall be placed in segregated housing in accordance with institutional services procedures regarding segregation units. The shift commander shall ensure the alleged victims and perpetrators are separated by sight and sound while housed in a segregation unit. Offenders who are victims and/or perpetrators in an alleged PREA event will be kept out of sight and sound from each other and be placed in separate wings. If the assessment is due to an offender being viewed as being in substantial risk of victimization in the absence of an allegation of offender sexual abuse, and temporary administrative segregation confinement (TASC) is recommended to ensure the offender's safety, the shift commander shall note the PREA risk on the TASC order and the offender shall be placed in segregated housing in accordance with institutional services procedures regarding segregation units. The PREA site coordinator shall review all PREA notification checklists the following business day to ensure appropriate housing placement. Assignment to involuntary segregation housing shall not ordinarily exceed a period of 30 days. Every 30 days, the offender shall be afforded a review to determine whether there is a continuing need for separation from the general population in accordance with institutional services procedures regarding segregation units and protective custody."

### ONISTE:

WRDCC provided four examples of classification hearing involving segregated housing based on the risk of victimization. These examples of classification hearings are from 2014 with the last one being dated November 2014.

### INTERVIEW:

Staff stated that anyone placed in segregated housing will still have access to programming as much as possible. If they are placed in segregated housing they have their first classification hearing within 5 days of placement.

RECOMMENDATION:

None

**Standard 115.71 Criminal and administrative agency investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Inspector General conducts all criminal case at WRDCC. Administrative agency investigations are also conducted at WRDCC.

DOCUMENTATION REVIEW:

Policy D1-8.1 Investigation Unit Responsibilities/Actions, page 5, Section III (A) (2) (3) states, "The department maintains a zero tolerance policy against offender abuse and offender sexual abuse. The PREA also prohibits sexual misconduct by staff members against an offender and offender against an offender. All such allegations will be thoroughly reviewed for potential investigation. The investigation unit, under the jurisdiction of the inspector general's office, is the investigative unit of the department. This unit conducts investigations in response to reports of violations of Missouri state law and serious violations of department procedure at all facilities throughout the state. The unit works closely with federal, state and local law enforcement agencies and the other divisions within the department to ensure criminal violators are prosecuted. The department may pursue prosecution of any staff member or offender who violates state law."

Page 7 of this same policy states, "The facility shall report all allegations of sexual abuse, including third-party and anonymous reports, in accordance with the department procedure addressing offender sexual abuse and harassment."

Page 10 of this same policy, Section H, outlines the investigators responsibilities. The policy states, "All investigators shall aid and assist in investigations as directed, and to the limit permitted, by the responsible law enforcement agency and the inspector general or designee. Investigators may be assigned outside their normally assigned region to assist in statewide investigations. Investigators shall conduct investigations into all allegations assigned for investigation promptly, thoroughly, and objectively. Investigators shall gather and preserve direct and circumstantial evidence, including any available physical, DNA evidence and any available electronic monitoring data; shall interview alleged victims, suspected perpetrators, and witnesses; and shall review prior complaints and reports of behavior involving the alleged victim and suspected perpetrator. Medical records or information related to offender sexual assaults and uses of force may be obtained from facility medical practitioners without authorization from central office. The credibility of a victim, suspect, or witness shall be assessed on an individual basis and shall not be determined by the person's status as an offender or employee. Investigations shall be documented in a written report that contains a thorough description of physical, testimonial and documentary evidence and attach copies of all documentary evidence where feasible. Administrative investigations shall include an effort to determine whether staff member actions or failures to act, contributed to the behaviors being alleged. The departure of the alleged abuser or victim from employment or control of the department shall not provide a basis for terminating the investigation. When an investigation reveals probable cause that an offender or staff member has committed, or is suspected of committing, an act in violation of local, state or federal law, the investigator conducting the investigation shall note in the investigative report that the case will be forwarded for prosecution consideration, and submit a request for prosecution packet. The prosecution packet will include at a minimum: the investigation report written by the investigator, a probable cause statement completed by the investigator that conducted the investigation, all relevant documentation associated with the investigation, and other information deemed necessary by the prosecuting attorney's office having proper jurisdiction...CAOs shall impose no standard higher than a preponderance of the evidence in determining whether allegations of offender sexual abuse are substantiated."

Policy D1-8.4 Administrative Inquiries, page 5, Section III, (A) states, "Any staff member having direct or indirect knowledge of a potential category I or IV behavior shall immediately notify the CAO by submitting a report of incident, or memorandum, through the chain of command. A copy of all reports of harassment, sexual misconduct, discrimination, or retaliation should be sent to the employee relations supervisor. Staff members must fully cooperate with all administrative inquiries and must fully and truthfully relate their knowledge of all

facts pertaining to the alleged behavior under review. Staff members who are the subject of a criminal investigation are not required to provide incriminating information about their own misconduct. However, in all other cases, staff members must fully cooperate with any investigation or administrative inquiry and truthfully relate their knowledge of all facts."

Pages 5 and 6 of this same policy discuss when an administrative inquiry may be conducted. This policy states, "An administrative inquiry may be conducted when a staff member may have been engaged in category I behaviors, or an offender may have been engaged in category IV behaviors. When the CAO receives information that a staff member may have been engaged in category I behavior, the CAO shall review the information and determine the appropriate course of action... The offender sexual abuse coordinated response will be initiated on all allegations of offender sexual abuse or harassment, including anonymous and third party allegations, in accordance with the department's procedure regarding offender sexual abuse and harassment. Based on the circumstances of the allegation, the CAO may immediately remove or reassign the staff member from having contact with the offender pending the outcome of an investigation, or the determination of whether and to what extent discipline is warranted, or if there is reason to believe the offender is being retaliated against by the staff member."

Auditor reviewed the Agency Records Disposition Schedule and found that records are retained for 50 years.

#### ONSITE:

WRDCC provided several examples of investigations that included those that resulted in findings of unfounded, unsubstantiated and also provided examples of "Requests of Investigations"

Auditor reviewed an investigation of Staff on Inmate Sexual Abuse which ended in June of 2015. Investigators interviewed the victim and alleged perpetrator as well as multiple witnesses. The case was closed with the following determination. "Evidence does not support a violation of statute; however, based on the evidence CKII XXXXXXXXX violated the following policies: D2-11.10, Staff Member Conduct- Section II 1 and 3 f, g; D2-111-10, Staff Member Conduct – Section II A 3a; and DOC Policy D2-11, Employee Standards – Section 1."

Auditor reviewed two cases of administrative inquiries: one case of substantiated inmate on inmate sexual harassment and one case of unsubstantiated staff on inmate sexual harassment. Both investigations were well written and thorough. They included interviews with the victim and alleged perpetrator as well as witnesses. In both cases, the investigations were concluded within 45 days of the date the report was received.

An example of an administrative inquiry of inmate on inmate sexual misconduct that resulted in an unfounded disposition was also reviewed. Again, the report was thorough and well written. The case was opened July 24, 2015 and was closed on August 7, 2015.

Another example of an administrative inquiry of employee on inmate sexual harassment that resulted in unfounded disposition was also reviewed as well as an unsubstantiated case of inmate on inmate sexual harassment.

Auditor reviewed three examples of requests for investigations of inmate on inmate sexual abuse. One case ended with the disposition of unfounded when it was determined that the inmate was trying to circumvent the system by making a false allegation. In this case, the inspector general made the determination not to investigate the case.

Auditor also reviewed three examples of an anonymous report received through kites and the PREA hotline. PREA protocol was initiated the day the reports were received.

Auditor reviewed the training roster from "PREA Specialized Investigator Training" dated January 1, 2013 through September 20, 2014. The roster showed that 56 investigators received this training during that time frame.

WRDCC provided four examples of case that were referred for prosecution; however, charges were not filed.

#### INTERVIEWS:

Administrative staff report all administrative cases are assigned by the Warden. Administration advised that requests for investigations are referred to the inspector general's office and they in turn make the determination if an investigation is going to be opened.

Investigative staff state they have received specialized PREA training and were able to explain what they covered in training including the discussion of DNA collection, Miranda, Garrity and interviewing victims. Investigative staff stated that all investigations are written in report form. They interview victims, alleged perpetrators, witnesses as well as review any video surveillance that is available. Staff also stated that they look at the totality of the investigation before making a determination. They do not look solely on the credibility of the victim. Investigations are not terminated until all facts and evidence is gathered. Staff stated they do not terminate an investigation when

the alleged perpetrator leaves the facility. (This includes staff.)

RECOMMENDATION:

None

**Standard 115.72 Evidentiary standard for administrative investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC imposes no higher standard of a preponderance of the evidence or a lower standard of proof when determining whether allegations of sexual abuse or sexual harassment are substantiated.

DOCUMENTATION REVIEW:

Policy DI-8.4 Administrative Inquiries, page 8, Section III (C) (9) states, "No higher standard than a preponderance of evidence in determining whether allegations of sexual abuse are substantiated."

ONSITE:

WRDCC also provided examples for this auditor to review. Auditor reviewed two cases of substantiated allegations of inmate on inmate sexual harassment. Both reports were well written and thorough. They included interviews with the victim, alleged perpetrator and witnesses. In one report, the investigator interviewed an inmate that was no longer at WRDCC. Both cases were closed within 35 days of being opened.

INTERVIEW:

Investigative staff stated they do not impose a higher standard of a preponderance of the evidence. They reported they take their investigations seriously and that sexual abuse and harassment is not tolerated.

RECOMMENDATIONS:

None

**Standard 115.73 Reporting to inmates**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has a policy requiring that any inmate who makes an allegation that he suffered sexual abuse is informed, verbally or in writing, as to whether the allegation has been determined to be substantiated, unsubstantiated, or unfounded following an investigation.

The Inspector General's office conducts all criminal investigations and WRDCC conducts administrative investigations.

#### DOCUMENTATION REVIEW:

Policy D1-8.13, Offender Sexual Abuse and Harassment, Reporting Outcomes, pages 23 and 24 states, "Upon the completion of a PREA investigation or inquiry regarding offender sexual abuse, the department's PREA coordinator shall make written notifications to the alleged victim regarding the outcome of the investigation or inquiry utilizing the applicable alleged sexual abuse by offender notification or the alleged sexual abuse by staff notification form. Notification shall not be made to the offender following an investigation or inquiry regarding sexual harassment. The initial notification shall state whether the allegation was substantiated, unsubstantiated, or unfounded. In the event that the investigation was conducted by an outside agency, the office of the inspector general shall request relevant information from the outside agency in order to inform the offender of the outcome of the investigation. All subsequent notifications shall be made when: Staff member on offender allegations: following the completion of an inquiry or investigation, the offender shall be notified when the following occurs unless the inquiry or investigation is unfounded:

- (1) Staff perpetrator is no longer assigned to the housing unit.
- (2) Staff perpetrator is no longer employed at the institution or department.
- (3) The staff perpetrator has been indicted on a charge related to sexual abuse within the institution.
- (4) A disposition of charges exists related to sexual abuse within the institution.

Offender on offender allegations: following the completion of an inquiry or investigation, the offender shall be notified when the following occurs.

- (1) The offender has been indicted on a charge related to sexual abuse within the institution.
- (2) A disposition of charges exists related to sexual abuse within the institution.

The departmental PREA coordinator shall forward the written notification to the offender via the PREA site coordinator. The PREA site coordinator shall ensure that the written notification is provided to the offender. If the investigation or inquiry involved offender-on-offender sexual abuse or harassment that was substantiated or unsubstantiated, written notification shall be delivered to the offender victim in a confidential manner. The offender shall be offered the notification letter but shall have the right to decline the letter. The original notification shall be signed by the offender or resident and witnessed by a staff member. The original notification shall be forwarded to the department's PREA coordinator for tracking. A copy of the notification shall be provided to the offender. The date the notification letter is delivered to the offender shall be documented in the chronological section of the offender's classification file. In the event the offender is no longer housed in an institution, community release center, or community supervision center the duty to report ends."

#### ONSITE:

WRDCC provided auditor with examples of notifications for review. Auditor reviewed four examples of inmate notifications.

#### INTERVIEWS:

Administrative staff reported that it is in policy that all offender victims are notified of the outcomes of their PREA cases. Investigative staff reported that notifications are made and also reported that this is part of policy.

The inmate who reported sexual abuse who was selected to be interviewed declined to participate in the audit process. However, when talking with other inmates, it was a mixed response on whether they "remembered" being notified on the outcome of their allegations.

#### RECOMMENDATION:

None

#### Standard 115.76 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the

relevant review period)

☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC has procedures in place to discipline staff for violating agency sexual abuse and sexual harassment policies. In the past 12 months, there has been no staff disciplined under this policy.

#### DOCUMENTATION REVIEW:

Policy D2-11.10 Staff Misconduct, page 4, Section III (A) (14) states, "In order to pursue organizational excellence staff members are expected to adhere to the following professional principles and conduct...report inappropriate actions, misconduct, offender or resident abuse, and sexual contact by staff members and offenders or residents to appropriate personnel."

Policy D1-8.13 Offender Sexual Abuse and Harassment, Section III (N), page 27 states, "Staff members shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment procedures. Termination from the department shall be the presumptive disciplinary action for staff members who have engaged in sexual abuse. All terminations for violations or the resignation of a staff member, who would have been terminated if not for their resignation, shall be reported to relevant licensing or accreditation bodies and law enforcement."

#### ONSITE:

While WRDCC reports that no staff has been disciplined in 2015; however, they did provide a log from the Division of Offender Rehabilitation Services that recorded staff discipline in 2013 and 2014. This log had five employees listed.

#### INTERVIEWS:

None

#### RECOMMENDATIONS:

None

#### Standard 115.77 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC requires that any contractor or volunteer who engages in sexual abuse be reported to law enforcement, unless the activity was clearly not criminal, and to any relevant licensing bodies.

In the past 12 months, there have been no contractors or volunteers engage in sexual abuse of inmates.



#### DOCUMENTATION REVIEW:

Policy D1-8.13 Offender Sexual Abuse and Harassment (Page 27 of SOP version) states, "Corrective action for contractors and volunteers: Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations."

Policy D2-13.1 Volunteers, page 11 -13, Section III (G) states, "All volunteers will be familiar with and adhere to the standards for professionalism, conduct, and job performance in accordance with the department policy and procedures regarding employee standards and staff member conduct. All offender sexual abuse and harassment allegations that occur in a department facility involving a volunteer will be referred for investigation. Volunteers may be subject to disciplinary action and/or termination. When disciplinary action is recommended, the volunteer supervisor shall submit documentation to the volunteer site coordinator outlining the reasons for such actions. The volunteer site coordinator shall provide the CAO with the recommendation and documentation. If the volunteer is a multi-location volunteer, the volunteer site coordinator requesting the disciplinary action shall provide a copy of the documentation to the volunteer site coordinator at the home base location and/or all other additional locations. If the CAO concurs, and the discipline requires suspension, the volunteer will be suspended and notified in writing within 5 working days that he is suspended and that the recommendation for disciplinary action is being sent to the volunteer services coordinator. The CAO shall forward a recommendation for disciplinary action to the supervisor of department volunteer services with all pertinent documentation. The volunteer services coordinator shall determine what, if any, disciplinary sanctions are warranted. Within 10 working days of receipt of the recommendation, the supervisor of department volunteer services shall provide written notice of discipline sanctions to the volunteer, CAO, volunteer site coordinator, and volunteer supervisor at all locations where the volunteer was approved to provide services..."

#### ONSITE:

None

#### INTERVIEW:

Administrative staff stated that all contractors and volunteers are subject to the same policies as regular employees when it comes PREA. Staff stated volunteer and contractors are expected to abide by the zero-tolerance culture of the facility.

#### RECOMMENDATION:

None

#### Standard 115.78 Disciplinary sanctions for inmates

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

At WRDCC inmates are subject to disciplinary sanctions only pursuant to a formal disciplinary process following an administrative finding that an inmate engaged in inmate-on-inmate sexual abuse. The facility will offer therapy, counseling or other interventions to interrupt that type of behavior. If an inmate makes a report in good faith, there will no disciplinary action.

#### DOCUMENTATION REVIEW:

SOP D1-8.13 Offender Sexual Abuse and Harassment, Section III (M), pages 26 and 27 state, "Offenders shall be subject to disciplinary sanctions or violations pursuant to a formal disciplinary process following an administrative finding or a criminal finding of guilt when the

offender engaged in offender on offender sexual abuse in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions. The disciplinary process shall consider whether an offender's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, shall be imposed in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions. The mental health notification memo (SOP Reference H) will be completed and forwarded to mental health staff for completion prior to concluding the disciplinary hearing. If found guilty of sexual abuse, the offender shall be referred to appropriate treatment (therapy, counseling) by mental health staff member, as available, in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions. An offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent to the contact in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions. The department prohibits all sexual activity between offenders. Consensual sexual activity between offenders will not be deemed sexual abuse and shall be addressed in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions."

Policy IS&SOP 19-1.1 Conduct Rules and Sanctions, Section II (Definitions) pages 2 and 3 state, "If the rule violation is a major violation, is serious in nature, threatens the safety and security of the institution, is for sexual misconduct, or involves the destruction of state or offender property the employee should immediately fill out a Conduct Violation Report (Attachment A) and not use an informal sanction." This policy also defines sexual activity as "Any sexual act; intentional touching, whether done by a foreign object or by physical human contact of a sexual part of another or of self, regardless of whether such touching is consensual, kissing, or fondling; or physical or verbal conduct of a sexual nature."

This policy also defines forcible sexual misconduct as "Using force, coercion or threats of force to obtain the compliance of another in any type of sexual activity." It defines sexual misconduct as "Engaging with another in any type of sexual activity; Engaging in the self-touching of one's sexual parts in view of others and inappropriately exposing one's sexual parts to others."

WRDCC provided a copy of a memo dated August 1, 2013 that was addressed to all Wardens and the subject was "PREA Protocols." The memo stated, "The date for full compliance with PREA standards is rapidly approaching. When fully implemented, our facilities will be better equipped to detect, prevent, and respond to incidents of offender sexual abuse and harassment. During our DAI Staff meeting yesterday, we discussed the PREA protocols that will move the department towards compliance with the PREA standards. While the procedure revisions are pending, we are implementing the PREA protocols, which were provided to you yesterday, as outlined below: To be implemented for PREA incidents that occur from this day forward: Segregated Housing for Protective Custody, Disciplinary Sanctions and Mental Health..."

#### ONSITE:

Auditor reviewed the Disciplinary Sanction Sheet that outlined the disciplinary process for forcible sexual abuse. This process outlines the responsibilities of the Adjustment Hearing Board as well as a Qualified Mental Health Professional. The process also states, "PREA mandates that the disciplinary process consider whether an offender's mental disabilities or mental illness contributed to his/her behavior when determining what type of sanction, if any, shall be imposed. If the facility offers therapy, counseling, or other interventions designed to address and correct underlying reasons or motivations for the abuse, the facility shall consider whether to require the offending offender to participate in such interventions as a condition of access to programming or other benefits. In this process it also states that an offender will not be issued a conduct violation for sexual misconduct involving a staff member unless the sexual activity is forced upon the staff member by the offender. In addition it states a report of offender sexual abuse made in good faith based upon a reasonable belief that the alleged conduct occurred shall not constitute falsely reporting an incident or lying, even if an investigation does not establish evidence sufficient to substantiate the allegation or the allegation is unfounded."

WRDCC reported that they did not have any incidents where an offender was issued a conduct violation for sexual contact with staff after finding that the staff member did not consent to such contact.

WRDCC provided an example of QMHP involvement in a substantiated case of sexual abuse. This example included documentation that an advocate was not requested for the purposes of the mental health evaluation. A summary of the evaluation was also provided.

WRDCC also provided two examples of violation reports of sexual misconduct when it was determined that sexual activity was not PREA related.

#### INTERVIEWS:

Administrative staff report that inmates are not punished for making a PREA allegation especially if it is made in good faith. Staff reported that this is in policy. After visiting with mental health staff, it was reported they are very active in hearings that involved

inmates. Mental health staff stated that their recommendations are taken under advisement by facility staff. Mental health staff was complimentary of how administration responds to all allegations.

#### RECOMMENDATIONS:

None

#### Standard 115.81 Medical and mental health screenings; history of sexual abuse

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Inmates housed at WRDCC are offered follow up meetings with medical or mental health professionals if they disclosed any prior sexual victimization. This is also offered to inmates who have previously perpetrated sexual abuse. Informed consent is obtained from inmates unless they are under the age of 18.

#### DOCUMENTATION REVIEW:

SOP DI-8.13 Offender Sexual Abuse and Harassment, page 10, Section III (C) (5) states, "If the screening indicates that an offender has experienced prior sexual victimization, whether it occurred in a correctional setting or in the community, staff members shall ensure that the offender is offered a follow-up meeting with a medical or mental health practitioner within 14 days of the intake screening. If the screening indicates that an offender has previously perpetrated sexual abuse, whether it occurred in a correctional setting or in the community, staff members shall ensure that the offender is offered a follow-up meeting with a mental health practitioner within 14 days of the intake screening. Medical and mental health practitioners shall obtain informed consent from offenders before reporting information about prior sexual victimization that did not occur in an institutional setting."

IS11-32 Receiving Screening – Intake Center, pages 4 -5, Section III (B) states, "If during the screening, the offender reports being sexually abused within the last 72 hours or if a forensic exam is deemed medically necessary, the coordinated response to offender sexual abuse will be initiated in accordance with departmental procedures regarding offender sexual abuse and harassment. If the screening indicates the offender has experienced prior sexual victimization and a forensic exam is not deemed medically necessary, the coordinated response protocol will not be initiated and the offender will be offered a follow-up meeting with a medical and/or mental health practitioner within 14 days of the intake screening. If the screening indicates the offender has previously perpetrated sexual abuse, whether it occurred in an institutional setting or in the community, staff members shall ensure that the offender is offered a follow-up meeting with a QMHP within 14 days of the intake screening. Health services staff members shall obtain informed consent from offenders in accordance with institutional services regarding informed consent before reporting information about prior sexual victimization that did not occur in an institutional setting, unless the offender is under the age of 18."

Auditor also reviewed the PREA Risk Assessment Manual --- many questions remind users that if marked "yes" they need to contact mental health. For example Question 1 of the Risk Assessment:

1. Have you ever been approached for sex/threatened with sexual abuse while incarcerated? (If the offender offers any information with regards to incident place information in the comments box, it is not necessary to get specific details. Determine if the incident was reported. Has the assailant been added to the victim's enemy listing? Determine if the offender needs Protective Custody or a Mental Health Referral...")

#### ONSITE:

WRDCC also provided copies of the "WRDCC PREA Event Log" and "WRDCC PREA Log for Mental Health." The PREA Event log had four entries; three from 2014 and one from 2015. This log tracks offender name, number, and date of PREA event. It also tracks the date the provider was notified as well as any hospital information. This log has provider referrals but not referrals to outside hospitals. The

PREA log for Mental Health tracks the offender name, DOC number, date mental health was notified as well as the name of staff that was assigned. Mental health saw 37 inmates for PREA related allegations.

#### INTERVIEW:

Mental Health staff indicated they obtain informed consent from every inmate that comes through. They stated if the inmate is under the age of 18, they contact the Site Coordinator, who handles the youth and arranges for the youth's transfer.

Interviews with inmates stated they knew if they wanted mental health assistance due to a PREA allegation they can request it through their Functional Unit Managers (FUM's.) Inmates stated they have never been denied access to mental health at this facility.

#### RECOMMENDATION:

None

### Standard 115.82 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Inmate victims of sexual abuse at WRDCC receive timely, unimpeded access to emergency medical treatment and crisis intervention services. They are also offered information and access to sexually transmitted infections prophylaxis. All services are provided at no cost to the victim.

#### DOCUMENTATION REVIEW:

Policy SOP D1-8.13 Offender Sexual Abuse and Harassment, pages 18-21 states, "Victims of sexual abuse shall receive timely, unobstructed access to emergency medical treatment and crisis intervention services, the nature and scope of which are determined by health services practitioners according to their professional judgment. When conducting a medical assessment of any victim or alleged or suspected perpetrator of an incident of sexual abuse or sexual harassment, health services staff members may not collect evidence but shall assist in the preservation of items related to the incident. Health services staff members should screen victims for obvious physical trauma, and at that time provide emergency medical care. If an allegation of offender sexual abuse is made within 72 hours of the event and consists of penetration of the mouth, anus, buttocks, or vulva, of any kind, however slight, by hand, finger, object instrument, or penis, the victim should be transported to the community emergency room with a sexual assault forensic examiner (SAFE) or sexual assault nurse examiner (SANE), when possible, for gathering of evidence. If it has been greater than 72 hours since the alleged abuse, and the alleged victim has not showered, they should be transported to the community emergency room with a sexual assault forensic examiner (SAFE) or sexual assault nurse examiner (SANE), when possible for gathering of evidence. Health services staff members should contact the shift commander and the community emergency room to arrange transportation to the emergency room in accordance with institutional services procedures regarding offender transportation and hospital and specialized ambulatory care. If the victim has showered and it has been more than 72 hours since the reported assault, the physician should determine treatment and whether or not the victim will be sent off site for a forensic exam. For investigative purposes, the investigator may choose to have the victim sent out for a forensic exam.

\*\*\*\*SOP The offender will remain in the medical unit until the investigator has determined whether or not the offender needs to go on medical out count.

When a forensic out count is indicated:

- a. Health services staff members should contact the shift commander and the community emergency room to arrange transportation in accordance with institutional services procedures regarding offender transportation and specialized ambulatory care. The

offender will be held in medical when possible until the arrival of the investigator. Through communication with the hospital, health services staff shall determine when the offender should arrive at the hospital to ensure prompt services. If the offender refuses a forensic exam, medical staff members will educate the offender on importance of forensic exams. If the offender continues to refuse a forensic exam, documentation of the refusal will be noted on the refusal of treatment - no show form.

\*\*\*\*SOP A copy of the refusal is to be sent to the PREA site coordinator.

Any emergency treatment provided should be documented, in SOAP format, in the applicable department computer system. Health services staff members should interact with the alleged victim in a neutral and non-judgmental manner. Health services staff members should ask the alleged victim for details of the incident that are important for the provision of health services. The health services related documentation of the alleged assault should be released only to the CAO or designee and the institutional investigator. Alleged victims of offender sexual abuse that consists of penetration of the mouth, anus, buttocks, or vulva, of any kind, however slight, by hand, finger, object instrument, or penis should be provided with prophylactic treatment and follow-up for sexually transmitted or other communicable diseases, as clinically determined by the physician. Female victims shall be offered timely information and timely access to pregnancy testing and emergency contraception in accordance with professionally accepted standards of care, where medically appropriate. If initial disclosure of offender sexual abuse is made to health services staff members, notification should be made to the shift commander to initiate the coordinated response to offender sexual abuse in accordance with this procedure.

\*\*\*\*SOP Health services staff are to also notify the PREA site coordinator. The reported perpetrator's health record will be reviewed by the health services administrator or designee and referred to the physician for appropriate communicable disease diagnostic testing. Upon receiving a report of a substantiated case of offender sexual abuse the PREA site coordinator will submit a referral and screening note - health services form to ensure the perpetrator will be assessed by qualified mental health professional (QMHP) within 60 days of learning of such abuse. If the allegation involves penetration and the offender is being out counted for a forensic exam and/or treatment, a QMHP will assess the victim within two hours of the offender returning to the facility. If the allegation involves penetration but the offender is not being out counted due to the amount of time that has elapsed since the time of the incident, a QMHP will assess the offender within two hours of receiving notification from the shift commander. If the allegation involves non-penetration, mental health staff members will receive a referral and screening note - health services from the shift commander and assessment will be offered within the next business day unless emergent events warrants a more immediate response by mental health staff members. During the initial assessment, mental health treatment interventions will be discussed with the victim by the QMHP and will include options such as individual and/or group therapy. The QMHP will explain and offer advocacy services to the alleged victim offender. Advocacy will not be offered for allegations of sexual harassment. The QMHP will document the offender's acceptance or refusal of advocacy services in the electronic medical record. If the offender refuses advocacy services the QMHP will have the victim sign the refusal of treatment/ no show form.

\*\*\*\*SOP A copy of the refusal of treatment form will be forwarded to the PREA site coordinator to be placed in the PREA event file. If the offender requests an advocate, the QMHP will notify the site advocacy liaison.

\*\*\*\*SOP A QMHP will notify the PREA site coordinator in writing or email when victim requests an advocate. PREA site coordinator will subsequently notify the investigative staff of victim's request for advocate. When the victim is out counted to MOSAIC Life Care for a SANE exam the hospital will contact the YWCA for advocacy services. When advocacy hours provided by the YWCA have been exhausted, the PREA site coordinator will notify the chaplain of the victim's request for an advocate. Institutional chaplain will meet with the victim and document the meeting, forward documentation to the PREA site coordinator to be placed in the PREA event file. If no qualified medical or mental health practitioners are on duty at the time a report of a penetration event that occurred within 72 hours within a correctional facility or 92 hours within a community confinement facility, custody staff first responders shall take preliminary steps to protect the victim and shall immediately notify the appropriate medical and mental health practitioners. Victims of sexual abuse shall be offered timely information and access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident. Each victim and abuser shall be offered medical and mental health evaluation, and as appropriate, treatment and include appropriate follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities or their release from custody. Victims and abusers shall be provided with medical and mental health services consistent with the community level of care in accordance with the institutional services procedures regarding medical and mental health services."

Auditor reviewed the contract requirements the MDOC has with Corizon. Pages 25 and 26 outline Corizon's obligations when obtaining medical care services from hospitals. The pages 42 - 45 outlines Corizon's experience with PREA, training regarding PREA, zero tolerance and mandatory reporting requirements if witnessing any form of sexual misconduct.

WRDCC's Coordinated Response to Offender Sexual Abuse addresses medical and mental health responsibilities for a penetration event and a non-penetration event.

For a penetration event:

Medical will:

- Assess the offender and process the medical out count to a hospital that utilizes Sexual Assault Nurse Examiners (SANE) to collect forensic evidence for an examination.
  - The listing of SANE hospitals can be found on the PREA intranet page.
  - WRDCC will utilize MOSIC Life Care for SANE Exams unless a SANE Nurse is not available.
  - If a SANE Nurse is not available the Shift Supervisor will work with Medical and the PREA Site Coordinator to send the offender to another SANE Hospital on the list.
  - MOSIC Life Care is to call the YWCA to provide advocacy service during the SANE Exam.
  - If YWCA is unable to provide advocacy services, the Chaplain Rotation List is to be utilized. The Rotation List is located on the I:Drive in the PREA folder.
- If the alleged victim refuses to submit to a forensic examination after speaking with the investigator, medical will have the offender sign the medical refusal form which will be forwarded to the PREA Site Coordinator to be attached to the PREA Event Checklist.
- Provide follow-up care upon offender's return from the medical out count.

Mental Health:

- Mental Health will respond within 2 hours of the offender's return from the medical out count.

For a non-penetration event:

- Mental health – Mental Health Referral Form – will respond no later than the next business day

ONSITE:

WRDCC also provided copies of the "WRDCC PREA Event Log" and "WRDCC PREA Log for Mental Health." The PREA Event log had four entries; three from 2014 and one from 2015. This log tracks offender name, number, and date of PREA event. It also tracks the date the provider was notified as well as any hospital information. This log has provider referrals but not referrals to outside hospitals. The PREA log for Mental Health tracks the offender name, DOC number, date mental health was notified as well as the name of staff that was assigned. Mental health saw 37 inmates for PREA related allegations.

INTERVIEW:

Mental health staff state that services start as soon as they are made aware of the need. They stated that if any medication is ordered during the SANE, orders would be sent to the facility and they would follow them. They also were able to articulate their first responder responsibilities if something were to happen inside the clinic.

RECOMMENDATION:

None

**Standard 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC offers medical and mental health evaluations/treatment to all inmates who have been victimized by sexual abuse in any

confinement settings. They also offer tests for sexually transmitted infections as medically appropriate. (NOTE: WRDCC is a male only facility.)

#### DOCUMENTATION REVIEW:

SOP D1-8.13 Offender Sexual Abuse and Harassment, page 21, Section III (G) states, "Victims of sexual abuse shall be offered timely information and access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate. Each victim and abuser shall be offered medical and mental health evaluation, and as appropriate, treatment and include appropriate follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities or their release from custody. Victims and abusers shall be provided with medical and mental health services consistent with the community level of care in accordance with the institutional services procedures regarding medical and mental health services. Victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests. If pregnancy results, the victim shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services."

#### ONSITE:

Auditor reviewed four examples of "Referral and Screening Note – Mental Health/Medical Service." Each referral note had documented observed behaviors, the reason for referral, screening results as well as actions taken by mental health and medical.

#### INTERVIEW:

Mental Health/Medical Staff stated that physical exams are always done on alleged victims. They always check to see if there is anything that is reportable. They advised that they do provide services that are consistent with the community. They advise they do everything but the forensic exams on site. They compared their services to what a citizen would find at an Urgent Care.

#### RECOMMENDATION:

None

#### Standard 115.86 Sexual abuse incident reviews

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

WRDCC conducts a sexual abuse incident review at the conclusion of every criminal or administrative sexual abuse investigations, unless the allegation is determined to be unfounded. They do this within 30 days of the conclusion of the investigation. Members of the review team include upper-level management, supervisors, investigators, and medical and/or mental health professionals. The members document their findings and any recommendations they may make.

#### DOCUMENTATION REVIEW:

SOP D1-8.13 Offender Sexual Abuse and Harassment, pages 22 and 23, Section III (I) states, "Each facility shall conduct a sexual abuse incident debriefing at the conclusion of every substantiated and unsubstantiated offender sexual abuse investigation or inquiry. A sexual abuse incident debriefing is not required on offender sexual harassment investigations or inquiries or if the investigation or inquiry is unfounded. Debriefings shall be held within 30 days of the conclusion of a formal investigation or inquiry utilizing the PREA sexual abuse debriefing form and submitted to the department PREA coordinator, CAO, and assistant division director. The review team for offender sexual abuse events shall include the PREA site coordinator, and other upper level administrators, when applicable, with input from



supervisors, investigator, and medical or mental health practitioners, when applicable. A complete written report shall be prepared by the CAO or designee outlining in detail the findings of the debriefing sessions and recommendations for improvements utilizing the PREA sexual abuse debriefing form. The written report will be prepared by the PREA site coordinator. The facility shall implement the recommendations for improvement, or shall document its reasons recommendations shall not be implemented. The completed report shall be stamped confidential and shall be submitted to the assistant division director with a copy to department's PREA coordinator. The assistant division director shall forward the report to the division director. A copy of the report shall be filed in the institutional PREA event file for future audits.

WRDCC provided a copy of their "Debriefing Protocol." This protocol states, "Debriefings shall be held within 30 days of the conclusion of a formal investigation or inquiry. Debriefings will be conducted at the conclusion of all sustained and not sustained offender sexual abuse investigations and inquiries, not sexual harassment inquiries. Debriefings will not be conducted if the allegation was determined to be unfounded. The review team for offender sexual abuse events should include PREA Site Coordinator, with input from line supervisors, investigator, and medical or mental health practitioners when applicable."

This protocol also states also outlines the components of offender sexual abuse debriefing as well as the required components of the PREA Debriefing report. All of this information is also to be included the department's annual report.

#### ONSITE:

Auditor reviewed three examples of reviews of sexual abuse incidents. These reviews included the name of the victim, assailant, staff members involved in the briefing, date and time of the incident, what occurred, location of the incident, housing information, was the allegation motivated by race, ethnicity or sexual orientation, information on the coordinated response, information on a forensic exam, mental health consultation, and any recommendations. These reviews are also included in the facility's annual report.

#### INTERVIEW:

Staff stated that they review each case and look for ways that can be done to make it better for the inmate and for the facility. They do not want prevent future incidents. Staff reported they always look at the totality of the incident when making recommendations.

#### RECOMMENDATION:

None

### Standard 115.87 Data collection

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Data needed to complete the annual Survey of Sexual Violence is collected in the Correctional Information Network (COIN) system. Data is collected and reviewed annually.

#### DOCUMENTATION REVIEW:

SOPDI-8.13, Offender Sexual Abuse and Harassment, page 3, defines offender on offender sexual abuse, offender sexual abuse and offender sexual harassment. They are defined as follows:

Offender on Offender Sexual Abuse: Sexual abuse of one offender by another offender includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:

1. Contact between the penis and the vulva or the penis and the anus, including penetration, however slight.
2. Contact between the mouth and the penis, vulva, or anus.
3. Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument.
4. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

Offender Sexual Abuse: Either offender on offender sexual abuse or staff member on offender sexual abuse.

Offender Sexual Harassment:

1. Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one offender directed toward another.
2. Repeated verbal comments or gestures of a sexual nature to an offender, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

ONSITE:

Auditor reviewed the 2014 PREA breakdowns for each facility in the MDOC.

Auditor reviewed the MDOC 2014 PREA Annual Report. This report contained information on the progress the department made in 2014 in PREA, a trend analysis of all investigations in the state and correction actions for each facility. This report is also published on the MDOC website at <http://doc.mo.gov/OD/PREA/php>.

INTERVIEW:

Administrative staff reported that data is collected monthly and reported annually to the PREA Coordinator.

RECOMMENDATION:

None

#### **Standard 115.88 Data review for corrective action**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

DOCUMENTATION REVIEW:

SOPD1-8.13 Offender Sexual Abuse and Harassment, pages 27 – 28 state, "Annual Site Report: Each facility shall utilize information from the offender sexual abuse debriefings to prepare an annual report to be submitted to the department's PREA coordinator by the last working day in March. The report shall include:

- (1) identified problem areas,

- (2) recommendations for improvement,
- (3) corrective action taken,
- (4) if recommendations for improvements were not implemented, reasons for not doing so,
- (5) a comparison of the current year's data and corrective actions with those from prior years, and an assessment of the facilities' progress in addressing sexual abuse,
- (6) an evaluation of the need for camera and monitoring systems,
- (7) in consultation with the PREA site coordinator; assessment, determination, and documentation of whether adjustments are needed to:
  - (A ) the staffing plan,
  - (B) the deployment of video monitors, and
  - (C) the resource availability to adhere to the staffing plan.

The yearly report shall be submitted to the division director and the department PREA coordinator no later than the last working day in March.

Agency Report: The PREA coordinator shall prepare an annual report compiling each facility's current year's data and corrective actions.

a. The report shall include:

- (1) a comparison with prior year's data,
- (2) corrective actions, and

(3) an assessment of the department's progress in addressing offender sexual abuse,

b. The report shall be forwarded to the department director for approval by the last working day in May.

c. The CAO or designee, PREA coordinator, and/or department director shall edit specific material from the reports when publication would present clear and specific threat to the safety and security of the facility.

(1)The CAO or designee, PREA coordinator, and/or department director shall indicate the nature of the material edited.

d. The department's annual PREA report shall be made available to the public on the department's internet website."

ONSITE:

Auditor reviewed the statewide annual report as well as the report as it relates specifically to WRDCC.

Auditor reviewed the 2014 PREA breakdowns for each facility in the MDOC.

Auditor reviewed the MDOC 2014 PREA Annual Report. This report contained information on the progress the department made in 2014 in PREA, a trend analysis of all investigations in the state and correction actions for each facility. This report is also published on the MDOC website at <http://doc.mo.gov/OD/PREA/php>.

INTERVIEW:

None

RECOMMENDATION:

None

#### Standard 115.89 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific**

### **corrective actions taken by the facility.**

The agency ensures that incident based and aggregated data are securely retained. According the Agency Records Disposition Schedule, this information is retained for five years, and then it is destroyed. There are no personal markers in the annual report and it is posted on MDOC's website for public viewing.

#### **DOCUMENTATION REVIEW:**

SOPD1-8.13 Offender Sexual Abuse and Harassment, page 28 states, "The department's annual PREA report shall be made available to the public on the department's internet website."

#### **ONSITE:**

Auditor reviewed the MDOC 2014 PREA Annual Report. This report contained information on the progress the department made in 2014 in PREA, a trend analysis of all investigations in the state and correction actions for each facility. This report is also published on the MDOC website at <http://doc.mo.gov/OD/PREA/php>.

#### **INTERVIEWS:**

None

#### **RECOMMENDATION:**

None

### **AUDITOR CERTIFICATION**

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

/s/ Elisabeth M. Copeland

*Elisabeth M. Copeland*

12/31/2015

Auditor Signature

Date

**PREA AUDIT REPORT   ☐ Interim   ☒ Final  
COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** September 11, 2015

<b>Auditor Information</b>			
<b>Auditor name:</b> Lynn Guyer			
<b>Address:</b> P.O. Box 86 Cottonwood, Idaho 83522			
<b>Email:</b> lguyer@q.com			
<b>Telephone number:</b> 208-507-1449			
<b>Date of facility visit:</b> August 10, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Farmington Community Supervision Center			
<b>Facility physical address:</b> 1430 Doubet Road, Farmington, Mo. 63640			
<b>Facility mailing address:</b> <i>(if different from above)</i> <a href="#">Click here to enter text.</a>			
<b>Facility telephone number:</b> 573-218-5006			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input checked="" type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> Nancy Bonacker			
<b>Number of staff assigned to the facility in the last 12 months:</b> 48			
<b>Designed facility capacity:</b> 30			
<b>Current population of facility:</b> 27			
<b>Facility security levels/inmate custody levels:</b> Community Supervision Center			
<b>Age range of the population:</b> 18 years and older			
<b>Name of PREA Compliance Manager:</b> Kristen Peppers		<b>Title:</b> Unit Supervisor, PREA Coordinator	
<b>Email address:</b> Kristen.peppers@doc.mo.gov		<b>Telephone number:</b> 573-218-5006	
<b>Agency Information</b>			
<b>Name of agency:</b> Missouri Department of Corrections			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Missouri Department of Correction			
<b>Physical address:</b> 2729 Plaza Drive, Jefferson City, MO 65102			
<b>Mailing address:</b> <i>(if different from above)</i> Same as above			
<b>Telephone number:</b> 573-751-2389			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> George Lombardi		<b>Title:</b> Director	
<b>Email address:</b> george.lombardi@doc.mo.gov		<b>Telephone number:</b> 573-526-6607	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Vevia Sturm		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> vevia.sturm@doc.mo.gov		<b>Telephone number:</b> 573-522-3335	

## AUDIT FINDINGS

### NARRATIVE

On August 10, 2015 a PREA Audit was completed at the Farmington CSC. Prior to the audit I reviewed all supporting documentation from the facility. The facility was very thorough in their documentation. I found that both staff and residents understood how to report any sexual abuse or harassment. They also understood that retaliation for making such a report is prohibited by the Missouri DOC. Residents and staff both stated that every morning a PREA announcement is made to include what gender of staff are on duty. Some residents could actually quote the reporting post that are in facility, due to as they explained, "While waiting for the phone there is nothing else to do but read the postings". While completing the tour of the facility, I was also able to visually see the posting concerning how to report sexual abuse or harassment.

During the tour of the facility it was pointed out that the facility had a PREA incident with a staff member against a resident. Even though the incident happened off site, it was discovered during the debriefing that the kitchen area posed a possible risk. The corrective action was to keep the kitchen window enclosure open at all times, and to place a security camera in the area.

### DESCRIPTION OF FACILITY CHARACTERISTICS

The Farmington CSC is a co-ed facility that houses residents who are preparing for parole, as well as those that have had violations on probation and placed by the courts. The lay out of the facility is an open dormitory type setting with individual cubicles. Residents who are deemed to be vulnerable or at risk, are placed in such a way for the staff to have better visibility of them. Residents who are deemed as possible abusers are also placed for more visibility, which is away from those considered vulnerable. The facility is well maintained, and staff were informative and respectful during the audit, as well as the residents. The facility has a very good lay out to reduce the ability for sexual abuse to occur. The control center has been upgraded with the type of video monitoring which includes one monitor that has numerous split screens to allow staff to see multiple areas at once, as well as other monitors. The system allows staff to record and review later if an allegation is reported. There is a design flaw with the facility which is in the male side restroom. There is an L in the toilet area where the staff cannot visibly see residents. This could put residents in danger of abuse or harassment. To fix this issue, the facility grated the area off and use it for storage.

The facility was clean and well maintained, with residents completing janitorial duties.

### SUMMARY OF AUDIT FINDINGS

I found the facility to be well ran. Staff understand PREA requirements, as well as the residents. I found that the residents were comfortable in understanding should they report sexual abuse or harassment, no retaliation would occur. Residents were able to explain where information was located should they need it for reporting incidents, as well as outside and third party reporting. Staff also understood what was required of them should an allegation come forward. While touring the facility, I was able to observe the posting throughout the facility that explained how staff or offenders could report abuse or sexual harassment.

While interviewing the onsite PREA Coordinator, the state PREA Coordinator and the District Administrator, it is apparent the Missouri DOC has taken the PREA standards seriously and work towards insuring compliance with the standards. The facility has an excellent design to allow staff observation of residents in order to detect or reduce abuse.

There was a design flaw within the facility on male side bathroom that created an L. This flaw made it impossible for staff to see in that area and it would have contributed to possible abuse. The facility grated that area off so no offenders have access to that area. It is now used as storage.

Number of standards exceeded: 4

Number of standards met: 35

Number of standards not met: 0

Number of standards not applicable: [Click here to enter text.](#)

### Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All offenders at Farmington Community Supervision Center receive a comprehensive presentation on the Sexuality Abuse Behavior Prevention and Intervention Program during the admission and orientation program. They also receive an associated pamphlet from the facility. All offenders are made aware the Missouri Department of Corrections has a zero tolerance policy regarding sexual abuse and sexual harassment, and they have the right to be free from retaliation for reporting such incidents. Offenders are educated on definitions of sexually abusive behavior; prevention strategies to minimize risk of sexual victimization while in Missouri DOC custody; methods of reporting an incident of sexually abusive behavior against oneself, and for reporting allegations of sexually abusive behavior involving other offenders, to include reporting procedures directly to regional staff, or to an outside agency if desired; treatment options and programs available to offender victims of sexually abusive behavior; and the monitoring, discipline, and/or prosecution of sexual perpetrators.

The initial orientation is completed the same day as arrival and includes the PREA, video which is not required for this type of facility.

### Standard 115.212 Contracting with other entities for the confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The facility does not currently contract with other entities for the confinement of their residents, however, a generic contract was provided that outlines the information that is required under this standard.

### Standard 115.213 Supervision and monitoring

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)



**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The facility provided a staffing plan that exceeds the DOC's policy. Policy requires that a minimum of two security staff be on duty at all times. Farmington's standard is three security staff on each shift plus a shift supervisor. While interviewing staff and reviewing their documents Farmington has not deviated from the staffing plan that they have established. In talking with the CAO, PREA Coordinator, Shift Supervisor and staff I verified that if the shift was going to be short they would hold current staff on duty over. They also have mandatory overtime policy for recalling staff to the facility to cover shortages.

Even though Farmington CSC has not deviated from the staffing plan each staff member was able to articulate the process to deviate from the plan. They would call the duty officer and report the necessity to deviate from the plan and start the mandatory overtime recall for staff.

The facilities video monitoring program is very sufficient. However when I was onsite the system was down, due to no fault of the staff but due to weather. I personally observed all cameras onsite and found them to be sufficient.

Missouri DOC requires an annual report that also includes a review of the facilities staffing pattern. Also each time the facilities security staff bid for their assigned post it is reviewed.

#### **Standard 115.215 Limits to cross-gender viewing and searches**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Farmington CSC is a fully staffed with security staff. Their staffing plan ensures that a female staff member is always on duty. In speaking with one male staff member he was upset not getting weekends or Sundays off. He stated he has a number of years with the agency but is always bumped due to needing a female officer on certain days. This indicates to me that the facility does an excellent job ensuring that a female is always available. While speaking with the Unit Supervisor Kristine she indicated the facility has enacted an alternative schedule that allows overlap between shifts. Also, talking with the onsite on site Unit Supervisor and other security staff they understand the prison facility across the street would provide a female staff member if needed. Based on the staffing pattern for the facility they have not needed to conduct any cross gender pat searches. While interviewing the staff they have all been trained in how to conduct cross gender pat searches. All staff interviewed also know that they are not allowed to search transgender or intersex residents to determine their genital status.

#### **Standard 115.216 Residents with disabilities and residents who are limited English proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The facility has not had the need to use a resident to assist in another resident reporting sexual abuse or sexual harassment. This is due to no residents with these issues having tried to report abuse or harassment. During the interviews with the staff they are aware of that use of resident interpreters; resident readers and other types of resident assistants are not prohibited except in limited circumstances where not using them would cause an extended delay.

The agencies also has a policy that covers the prohibited use of these types of residents and circumstances where they would be allowed.

#### **Standard 115.217 Hiring and promotion decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Corrections has policy which this auditor has reviewed that covers the PREA standards. Also in interviewing the Onsite Unit Supervisor, CAO and the State PREA Manager they were all able to articulate that the Missouri DOC follows the PREA standard.

The agency shall not hire or promote anyone who may have contact with residents, and shall not enlist the services of any contractor who may have contact with residents, who—

Has engaged in sexual abuse in a prison, jail, lockup, community confinement facility, juvenile facility, or other institution (as defined in 42 U.S.C. § 1997);

Has been convicted of engaging or attempting to engage in sexual activity in the community facilitated by force, overt or implied threats of force, or coercion, or if the victim did not consent or was unable to consent or refuse; or Has been civilly or administratively adjudicated to have engaged in the activity described in paragraph (a) (2) of this section.

The agency shall consider any incidents of sexual harassment in determining whether to hire or promote anyone, or to enlist the services of any contractor, who may have contact with residents.

#### **Standard 115.218 Upgrades to facilities and technologies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

There have been no significant upgrades to the facility since 2012.

#### **Standard 115.221 Evidence protocol and forensic medical examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The facility has not had an incident where it was necessary for have a forensic medical examination. However while interviewing the unit supervisor and the line staff they understand the process for collecting and maintaining evidence in a possible crime scene. The Missouri Department of Corrections provides investigators from their prison facilities. The Farmington CSC is assisted by the Farmington Prison which is located in close proximity of the CSC. The investigator works directly with the local prosecutor on filing charges if the allegation is found substantiated. The investigator have all received training in conducting investigation and collecting evidence.

While interviewing the residents they were able to explain should they report a sexual abuse harassment what services would be available to them.

#### **Standard 115.222 Policies to ensure referrals of allegations for investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Corrections has policy that includes both administrative and criminal investigations are completed for all allegations of sexual abuse and sexual harassment. In the last twelve months the facility has had one report of sexual abuse by a resident against a facilities staff member. The investigation was assigned to the Fulton Prison Investigator office and was found substantiated. It was referred to the local prosecutor for prosecution.

#### **Standard 115.231 Employee training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing staff it was apparent that they have all be trained in the Department's zero tolerance policy, how to fulfill their responsibilities as it relates to sexual abuse, harassment prevention, detection reporting and response. They also understand the resident rights to be free for sexual harassment and retaliation for reporting those allegations. The staff also understand that they are free from retaliation for reporting that an offender is being sexually harassed or abused. Staff were able to identify the dynamics of sexual abuse and harassment in a confined facility and what to look for in an offender's behavior that would indicate may have been abused or harassed. The staff were able to explain how to detect actual sexual abuse and threatened abuse. All staff knew it is a felony to have an inappropriate relationship with a resident. They also understood that even if not a resident if the individual is under the supervision of Missouri Department of Correction it would constituted a policy violation and employment termination. Even though the facility does not have any transgender or intersex residents all staff stated they understood how to communicate professionally with them. They do have residents who are gay, bisexual and lesbian and non-gender conforming. Staff all indicated they are trained how to communicate with these individuals professionally. The comments from staff were we treat everyone the same no matter their ethnicity, religion or sexual preference or sexual identification. All staff have received a refresher on this training which is every twelve months. The training is online and covers all areas.

#### **Standard 115.232 Volunteer and contractor training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Correction and Farmington Community Supervision Center have protocol and policy to train all volunteers. This was verified through the state PREA Coordinator.

#### **Standard 115.233 Resident education**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All residents on the day they enter the CSC, whether they are coming from another facility or from probation, receive an orientation that includes the zero tolerance to sexual abuse and harassment, their right to be free from retaliation for reporting such incidents. The residents also understood the process for reporting incidents to include in writing, verbal, third party and the PREA hotline. The PREA video is also provided to the residents which is not required for this type of facility. The auditor reviewed documentation showing all information that the residents receive when they arrive. While interviewing the residents they all verified that they had received the orientation the day they arrived and were able to articulate their understanding of the Zero tolerance stance. The residents stated and the auditor observed that information concerning PREA reporting and resident's rights are posted throughout the facility. The auditor also reviewed the resident handbook which also contains all the information.

Security staff that were interviewed also verified that they provide the PREA orientation the day the resident arrives. Giving each offender all information concerning zero tolerance and viewing the PREA video.

#### **Standard 115.234 Specialized training: Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In interviewing the investigator from the Farmington Prison he was able to articulate and proved his specialized training as it pertains to PREA investigation. The auditor was also able to review the department's requirements for investigator training. Even though he has not completed any at the Farmington CSC he has conducted numerous investigations at the Prison. There are three investigators that are available to assist the Farmington CSC if an allegation arises and fourteen other investigators within the area.

#### **Standard 115.235 Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Farmington CSC has no onsite medical or mental health professionals. Documentation provided by the CSC shows that residents can be referred to BJC Behavioral Health for mental health needs. The program is funded through the Department of Mental Health Contract for offenders under the supervision of Missouri Department of Corrections Probation/Parole division.

#### **Standard 115.241 Screening for risk of victimization and abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Upon arrival every offender is screened for risk of sexual abuse, victimization or sexual abusiveness toward other residents. This auditor also reviewed the screening tool which covered all aspects of the standard. The facility has in place and was observed by the auditor

placement for each of these three categories to give more visibility. The agency has a policy that requires the facility to conduct a reassessment after thirty days. While interviewing staff and residents they both indicated that this screening took place the day they arrived and again 30 days afterwards. The agency has a policy in place prohibiting disciplining residents from not answering questions on the screening tool. Offenders interviewed all indicated that they were willing to participate in the screening process.

#### **Standard 115.242 Use of screening information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The auditor reviewed the agency policies regarding the use of the screening tool. The living area for both male and female residents has designated areas for those deemed at risk for sexual abuse or victimization and those that are considered sexual abusive to other residents. The facility keeps the residents that are at risk or victimization away from those that are deemed possibly sexually abusive towards other residents. The residents that at risk are kept in a more visible area. The facility has in place procedures so that the potential perpetrators are not assigned to work assignment with those that are at risk. This procedure would also be in place for transgender and intersex residents, however the facility has not had any of these individuals admitted to their facility as of yet.

#### **Standard 115.251 Resident reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Both staff and residents were able to articulate the process for reporting sexual abuse or harassment. Residents understood that they were immune from retaliation from reporting incidents. Staff were able to identify policy that restricts retaliation for reporting abuse. Staff also understood that if the abuse occurred because of staff neglect or violation of responsibility they were mandated to report it. They also understood that failure to do so would constitute disciplinary action against them.

While interviewing residents they were able to identify the ways in which they could report abuse whether it was against them or someone else. Each resident interviewed explained where the information was posted and the different ways in which to report the abuse.

While interviewing staff they all stated that a verbal report of abuse was allowed. Every staff member also stated the information would be documented immediately as allowed. Even though each staff member indicated they did not understand why a staff member would need to report abuse privately they identified the ways they could. Through the PREA hotline, telling someone else or submitting anonymously.

#### **Standard 115.252 Exhaustion of administrative remedies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri Department of Corrections has policy covering administrative process regarding resident's grievances regarding sexual abuse. The agency has a policy that includes allowing a resident to report any sexual abuse or harassment no matter the time that has lapsed. While interviewing the Unit Supervisor/PREA Coordinator it was confirmed that offenders are allowed to report abuse at any time. Residents are not required to follow the informal process in reporting any abuse. The facility/agency has policy that does not require the resident to grieve the staff member who is subject of the complaint; the agency's policy does require that the resident receive notification within 90 days whether the allegation is substantiated, unsubstantiated, or unfounded. There has been no grievances filed in the last twelve months.

The agency has policies that include third party reporting. All staff and residents understood that this was an option for them.

#### **Standard 115.253 Resident access to outside confidential support services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While conducting the tour of the facility this auditor observed numerous postings of outside resources the residents could access. The residents also knew that while out on work release or free time they could make contact with outside agencies. The residents also were aware that the information they discussed was confidential unless they requested it not be, that they were in danger of hurting themselves or others, or if they wanted to file charges.

#### **Standard 115.254 Third-party reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All staff and residents interviewed understood that they were able to report any sexual harassment or abuse through a third party.



### Standard 115.261 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All staff interview were aware that failure to report any sexual abuse or harassment was prohibited by policy. The agency's policy D1.8.13 also covers the failure to report: Failure to report offender sexual abuse is a class A misdemeanor. All staff members, volunteers, and contractors shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility and any knowledge of retaliation against offenders or staff members who reported such an incident and any staff member neglect or violation of responsibilities that may have contributed to an incident or retaliation in accordance with this procedure.

- a. Medical and mental health staff members shall inform offenders of the practitioner's duty to report at the initiation of services.
- 8. Staff members are prohibited from revealing any information related to an allegation of offender sexual abuse or harassment other than to the extent necessary to make treatment, investigation, and other security and management decisions.

### Standard 115.262 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In interviewing the staff at Farmington they were all aware that if a resident was in imminent danger of sexual abuse or harassment they would take steps to insure the individual was safe. That would either be done through bed placement moving the resident to another facility or removing the threat.

### Standard 115.263 Reporting to other confinement facilities

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In interviewing the staff and residents at Farmington they have had no residents that have reported abuse or harassment that occurred in another facility. The staff were able to explain that during the intake process should an offender reveal abuse at a different facility how they were to deal with that information and to report it.

#### **Standard 115.264 Staff first responder duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Each staff member that was interviewed was able to articulate the process that the first responder was required to do. First to protect the victim and make sure that the accused and the possible victim are separated. They also were able to explain the process of ensuring that the alleged abuser does not take any actions that could destroy physical evidence, including, as appropriate, washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating.

#### **Standard 115.265 Coordinated response**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Staff were able to explain what a coordinated response required when an accusation of sexual harassment or abuse was made by a resident. The facility also has a written process for that response which the auditor reviewed.

#### **Standard 115.266 Preservation of ability to protect residents from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri Department of Corrections Policy D2-11.6 covers collective bargaining that restricts the union from restricting the agency from taking action against an alleged abuser: **F. NEW AND/OR RENEWAL OF COLLECTIVE BARGAINING AGREEMENTS**

1. Per the Prison Rape Elimination Act, the department shall not enter into or renew any collective bargaining agreements or other agreements that limit the department's ability to remove alleged staff sexual abusers from contact with any offender or resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

#### **Standard 115.267 Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing both staff and residents they understood that retaliation for reporting any type of abuse was not allowed. This auditor also reviewed Missouri Department of Corrections policy D1-8.13 which covers both staff and residents rights to be free from retaliation for reporting any abuse or harassment.

#### **Standard 115.271 Criminal and administrative agency investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing the investigator from the Farmington Prison he was able to articulate the criminal investigation process. The investigation and the staff interviewed understood the difference between criminal and administrative investigations and the process that was included. Concerning the administrative process all staff understood that the administrative side was whether staff's actions or inaction contributed to the incident.

#### **Standard 115.272 Evidentiary standard for administrative investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

This auditor reviewed the documentation provided by the Missouri Department of Corrections which included standards for administrative investigations. This is covered in SOP D1-8.1 section: **Preponderance of Evidence: Enough proof to show that something is more likely to have occurred than not to have occurred.**

11. **CAOs shall impose no standard higher than a preponderance of the evidence in determining whether allegations of offender sexual abuse are substantiated.**

### **Standard 115.273 Reporting to residents**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The agency and the facility has policy and procedure on reporting back to residents allegations.

### **Standard 115.276 Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

During the past twelve months the Farmington CSC has had one allegation against a staff member which was substantiated. Missouri Department of Corrections policy D2-11.10 covers actions that would be taken concerning an allegation:

14. **report inappropriate actions, misconduct, offender or resident abuse, and sexual contact by staff members and offenders or residents to appropriate personnel**

#### **D. REPORTING MISCONDUCT:**

1. **Staff members having knowledge of any instances of offender or resident abuse or sexual contact with an offender or resident shall immediately report such to the inspector general in accordance with the department procedures regarding offender physical abuse and offender sexual abuse and harassment.**

#### Standard 115.277 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

During my interviews with the Unit Supervisor and CAO they both were aware of the policy concerning inappropriate behavior of contractors or volunteers. They both explained that should an allegation come forward the volunteer or contractor would be removed from contact with the residents until the allegation was substantiated, unsubstantiated or unfounded. If unfounded the volunteer or contractor would be allowed contact again with the residents.

##### **Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

#### **4. Corrective action for contractors and volunteers:**

- a. Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement.
- b. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations.

#### Standard 115.278 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Based on the type of facility the Farmington CSC is the alleged abuser is removed from the facility and either placed into a prison facility or county jail. So the follow-up with counseling and mental health determination is completed at the other facility. Missouri Department of Corrections D1-8.13 covers the consequences of the individual accused of being the abuser which follows them to the other facility.

#### Standard 115.282 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Staff at the Farmington CSC all understood what was available for emergency medical and mental health services were available. Staff that were interviewed all understood their duties to protect the victim pursuant to PREA standard 115.262. The Farmington CSC has had one allegation in the last twelve months which was substantiated.

#### **Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing the onsite supervisor and CAO they were both knowledgeable that should an allegation arise that the facility would be required to provide these services.

#### **Standard 115.286 Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Unit Supervisor was able to explain what a sexual abuse incident review entailed. The District Administrator had difficulty explaining the process but as we talked about it she was able to provide the information.

#### **Standard 115.287 Data collection**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific**

### **corrective actions taken by the facility.**

Documentation provided by the agency was reviewed and verified on their website. Missouri DOC Policy 115-87.F covers the requirements for data collections. The SSV is completed annually as well as the PREA report for each facility. These reports as verified by the auditor are posted on the Missouri DOC website.

#### **Standard 115.288 Data review for corrective action**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In reviewing the reports provided by the state PREA manager and the Farmington CSC facility the reports provided corrective actions or problem areas. During the past twelve months a substantiated sexual abuse occurred with a Farmington CSC resident. During the review for corrective action the facility put a camera in the kitchen and open the wooden window that covered visible access. It should be noted that this is not where the abuse occurred but was determined to be an at risk area. The CAO, Onsite Supervisor and State PREA Coordinator all stated that the Missouri DOC provides all PREA reports on their website. This auditor also verified this.

#### **Standard 115.289 Data storage, publication, and destruction**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The agency provided and the auditor confirmed that the data is stored with Inspector General and the Missouri Department of Corrections. The information is also available on both agencies websites. Pursuant to PREA standard 115.287 records are kept for 10 years and all names and personal identification is removed.

### **AUDITOR CERTIFICATION**

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.



Lynn S. Guyer

Auditor Signature

September 11, 2015

Date

**PREA AUDIT REPORT   ☐ Interim   ☒ Final**  
**COMMUNITY CONFINEMENT FACILITIES**  
**Date of report:** September 1, 2015

<b>Auditor Information</b>			
<b>Auditor name:</b> Lynn S. Guyer			
<b>Address:</b> P.O. Box 86, Cottonwood, Idaho 83522			
<b>Email:</b> lguyer@q.com			
<b>Telephone number:</b> 208-451-6535			
<b>Date of facility visit:</b> August 11, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Fulton Community Supervision Center			
<b>Facility physical address:</b> 1397 State Road O, Fulton Mo. 65251			
<b>Facility mailing address:</b> <i>(if different from above)</i> P.O. Box 6008, Fulton Mo. 65251			
<b>Facility telephone number:</b> 573-592-4061			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> Karen Dugan      Dungan			
<b>Number of staff assigned to the facility in the last 12 months:</b> 43			
<b>Designed facility capacity:</b> 32			
<b>Current population of facility:</b> 25			
<b>Facility security levels/inmate custody levels:</b> Field Supervision			
<b>Age range of the population:</b> 18 Plus			
<b>Name of PREA Compliance Manager:</b> Denise Kingsley		<b>Title:</b> Unit Supervisor/PREA Coordinator	
<b>Email address:</b> denise.kingsley@doc.mo.gov		<b>Telephone number:</b> 573-592-4061	
<b>Agency Information</b>			
<b>Name of agency:</b> Fulton Community Supervision Center			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Missouri Department of Correction			
<b>Physical address:</b> 2729 Plaza Drive, Jefferson Mo. 65102			
<b>Mailing address:</b> <i>(if different from above)</i> N/A			
<b>Telephone number:</b> 573-751-2389			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> George Lombardi		<b>Title:</b> Director	
<b>Email address:</b> George.lombardi@doc.mo.gov		<b>Telephone number:</b> 573-526-6607	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Vevia Sturm		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> vevia.sturm@doc.mo.gov		<b>Telephone number:</b> 573-522-3335	

## **AUDIT FINDINGS**

### **NARRATIVE**

On August 11<sup>th</sup>, 2015 I conducted an audit of the Fulton CSC. I arrived at the facility at 0800 and completed a briefing with the Unit Supervisor, District Administrator and the state PREA Coordinator. I explained the process of the audit and my time schedule. Based on the size of the facility, which is small, I communicated I would be at the facility approximately six hours. After conducting the briefing, Fulton staff conducted a tour with me. I was able to see the video components for the facility which were adequate for the size and layout of the facility. I also observed numerous posting throughout the facility on the agency's zero tolerance policy to sexual harassment and abuse and how to report any harassment or abuse. I also found the facility to be very conducive for staff to detect abuse or harassment and the ability for residents to report. The audit was completed at 1430 with the out briefing.

### **DESCRIPTION OF FACILITY CHARACTERISTICS**

The layout of the facility is an open dormitory type setting with individual cubicles. Residents who are deemed to be vulnerable or at risk are placed in such a way for the staff have better visibility of them. Residents who are deemed as possible abusers are also placed for more visibility which is away from those considered vulnerable. The facility is well maintained, staff were informative and respectful during the audit as well as the residents. The facility has a very good lay out to reduce the ability for sexual abuse to happen. The control center has been improved with the type of video monitoring which includes one monitor that have numerous split screens to allow staff to see multiple areas at once as well as other monitors. The system allows staff to record and review later if a later allegation is reported. There is a design flaw with the facility which is in the male side restroom. There is an L in the toilet area where the staff cannot visibly see residents. This could put residents in danger of abuse or harassment. However, to fix this issue, the facility grated the area off and uses it for storage.

The facility was clean and well maintained with residents completing janitorial duties.

### **SUMMARY OF AUDIT FINDINGS**

I found the facility to be well run. Staff understands PREA requirements as well as the residents. I found that the residents were comfortable that should they report sexual abuse or harassment that no retaliation would become them. Residents were able to explain where information was located should they need it for reporting incidents as well as outside and third party reporting. Staff also understood what was required of them should an allegation come forward. While touring the facility, I was able to observe the posting throughout the facility that explained how staff or offenders could report abuse or sexual harassment.

While interviewing the onsite PREA Coordinator, the state PREA Coordinator and the District Administrator it is apparent the Missouri DOC has taken the PREA standards seriously and work towards insuring compliance with the standards.

Number of standards exceeded: 2

Number of standards met: 37

Number of standards not met: 0

Number of standards not applicable: 0

### Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Corrections has policy which outlines their zero tolerance towards sexual harassment and abuse. The agency has established a statewide PREA Coordinator and onsite coordinator which title is Unit Supervisor. This auditor reviewed the policy and interviewed both the statewide PREA Coordinator and onsite Coordinator who both explained the zero tolerance policy. In interviewing staff and residents they both understood there was a policy which protected them against both sexual abuse and harassment.

### Standard 115.212 Contracting with other entities for the confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton does not have any contracts for confining their residents with other agencies.

### Standard 115.213 Supervision and monitoring

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

This auditor reviewed the staffing pattern which is adequate for the facility. The facility is currently down 4 security staff members which has a major impact on their security staffing. They have maintained having three officers on shift at all times, however it has created the issue of not always having a female on duty all times. The facilities video monitoring system is very good. The control center is able to observe all areas of the facility as well as go back and review video if necessary. Only staff that is authorized is allowed to review the recorded video.

While touring the facility this auditor found the layout of the facility to be very conducive to preventing sexual abuse and harassment. The facility recognized in the male restroom an area that was not observable by camera or staff. The facility grated that area off and uses it for

storage which the residents do not have access to.

Fulton is a co-ed facility in which the offenders are separated. When a resident arrives they are screened for their risk to be an abuser or be abused. Those residents are placed accordingly so that staff has more visual with them.

#### **Standard 115.215 Limits to cross-gender viewing and searches**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

At the time of the Fulton CSC Audit the facility was down four security staff members which required male staff to conduct pat searches of female residents. The facility keeps a log that tracks all cross-gender pat downs. There were no cross-gender strip searches. While interviewing staff and residents both stated at no time were they seen undressed or using the shower or bathrooms by opposite gender staff. Staff stated they never strip search a resident to determine if a resident is transgender or intersex. Offenders interviewed all stated they had not been subject to these searches.

This auditor reviewed training records that showed all staff was trained in conducting cross-gender pat searches, transgender pat searches and intersex searches. All staff interviewed stated that they treat all offenders professionally no matter their sexual orientation, race religious beliefs or any other issues.

#### **Standard 115.216 Residents with disabilities and residents who are limited English proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

During the interviewing of staff and residents they were all aware that it is prohibited to use resident interpreters, readers or other types of assistance to report sexual harassment or abuse. They also understood that in certain situations the use of these individuals is acceptable if not using them would create a delay in the process. The facility has in place the process to obtain assistants for residents with disabilities or language issue that are outside the facility.

### Standard 115.217 Hiring and promotion decisions

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Correction has policy in place that restricts the hiring, promoting or contracting with an individual that has been adjudicated, or investigated. All contractors, volunteers, part time employees and interns are required by Missouri DOC Policy and Procedure to take training concerning PREA requirements. The Missouri DOC requires that before new hires are offered employment a PREA check list must be completed, which includes if they have been employed by any other prison, community confinement, community treatment facilities, lockups etc. This check list includes whether the individual has been disciplined or charged with sexual abuse or harassment of a resident. Prior to promotions the Missouri DOC's Central Office Human Resource office must research the individual's personnel file to see if they have had any substantiated complaints of harassment or abuse. This is verbatim from Missouri DOC Policy and Procedure:

4. Prior to approval of a promotional appointment, regardless of the salary range, a check will be conducted of the employee's official personnel file through central office human resources. This check will be performed to ensure the employee has received no formal discipline for sustained allegations of sexual abuse and/or harassment or any information indicating any pending or adjudicated criminal charges. All sustained allegations will be considered by the department before an employee is promoted.

### Standard 115.218 Upgrades to facilities and technologies

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The only upgrade to the facility is their video monitoring system. The enhancement allows more ability to monitor the facility in real time. This is done by having split viewing on one monitor, as well as multiple monitors. There have been no other substantial upgrades to the facility.

### Standard 115.221 Evidence protocol and forensic medical examinations

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While conducting interviews with Fulton staff members they all understood the process for when a PREA incident was reported. Staff stated their first responsibility was to the safety of the resident and to protect the possible crime scene. Staff was able to articulate the basics of evidence protocol. They also were able to explain who investigates PREA incidents which is the investigators from the Fulton Prison which is located in close proximity. I interviewed one resident who was sexually abused by another resident while on the transport van. This resident stated they received medical attention and counseling. They were also allowed to make a phone call for support, which they called their spouse at Hannibal CSC. The resident stated they were interviewed by a DOC investigator and was given options for outside counseling services but declined them.

While interviewing the Unit Supervisor and District Administrator they stated they were aware of the allegation, however did not indicate if the incident was investigated. While reviewing the supporting documentation this auditor found that there were no investigation referrals concerning this incident or any other. After the writing of this report and upon review of the Fulton CSC staff and the State PREA Coordinator it was reported that this incident was in fact investigated by the IG's office and found unfounded. However the documentation does not show that there was a referral. This auditor does believe that the facility did follow the guidelines just did not maintain the documentation. This is based on what the resident stated to this auditor.

#### **Standard 115.222 Policies to ensure referrals of allegations for investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri Department of Corrections has policies and procedures in place to insure referrals of all allegations are investigated. Staff was able to explain the process for contacting the internal investigator for Missouri DOC. All Missouri investigators have had specialized training in investigations of PREA incidents. While interviewing one resident who had been sexually abused by another resident while being transported in the facility's van explained how their allegation was handled, which included their response to the allegation, how they were treated during the investigation and the follow-up, which covered the entire standards requirement.

#### **Standard 115.231 Employee training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While reviewing supporting documentation from the Fulton CSC and interviewing staff it was apparent that all staff has been trained and given a refresher training every twelve months. There is also a mandate by the Director of Missouri DOC that requires all existing and new



staff, interns, contractors and volunteers receive training on Sexual Abuse and Harassment against DOC residents. It also mandates that every twelve months these individuals will take a refresher on the training which is provided online.

#### **Standard 115.232 Volunteer and contractor training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

In discussions with the State PREA Coordinator, the CAO of the facility and the Unit Supervisor/PREA Coordinator it was evident that volunteers and contractors are given training on the requirements of reporting any sexual harassment or sexual abuse towards a Missouri DOC resident. Missouri DOC's policy states:

3. The volunteer site coordinator or designee will ensure record checks are completed as part of the approval process including:
  - a. criminal history checks,
  - b. an offender visiting record check,
  - c. former employee/volunteer record check,
  - d. if applicable, contact current institutional employer pertaining to information on sustained allegations of offender or resident sexual abuse and/or harassment, and
  - e. a check will be conducted through volunteer services to ensure there have been no sustained allegations of sexual abuse and/or harassment of an offender or resident.

#### **Standard 115.233 Resident education**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Upon arrival or within the first twenty four hours all residents are provided a PREA orientation to include sexual orientation perceived orientation, their concerns for safety or vulnerability. This auditor observed in numerous posting throughout the facility how to report sexual harassment or abuse. While interviewing staff and residents it was confirmed that these orientations are conducted, they also state that every morning a PREA announcement is placed over the intercom that explains the zero tolerance and how to report any incidents of sexual abuse or harassment. These announcements also include opposite sex staff on duty. All residents and staff knew how they could report sexual abuse or harassment. Staff and residents also knew how they could make a report privately. Even though the facility has not the issue of having English as a second language or disabilities in understanding the information they all knew how to obtain assistance for this. Missouri also has policy which this auditor observed that covers this issue. Each resident interviewed indicated that every time they have been transferred between facilities they have been given this orientation.

#### **Standard 115.234 Specialized training: Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC requires all new investigators to receive specialized training on how to conduct PREA investigations. While interviewing investigative staff at the Farmington CSC it was confirmed that all investigators are required to obtain specialized training in conducting PREA investigations. Also, while interviewing the state PREA Coordinator and on site PREA Coordinator it was confirmed that all Missouri DOC investigators receive specialized training in PREA investigations. Also the Missouri DOC policy states verbatim:

b. All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training by the designated inspector general's office staff members

#### **Standard 115.235 Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Fulton CSC does not have any medical or mental health providers on staff; however they do have MOU's with local providers that are trained in PREA responses.

#### **Standard 115.241 Screening for risk of victimization and abusiveness**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific**

### **corrective actions taken by the facility.**

The Fulton CSC conducts a screening of all residents within the first 24 hours of arrival at the facility and again in 30 days. This auditor was able to confirm this with interviews with the staff and residents. All residents were able to articulate what questions were asked which are required by the PREA standard. The screening tool which was observed by this auditor and confirmed with the interviews of staff and residents confirmed that areas covered included the residents past incarceration history, their concern of safety, their sexual orientation, criminal history, their sexual orientation or their perceived sexual orientation. None of the residents interviewed indicated they had refused to answer any of the screening questions; however the Missouri DOC has policy that prohibits disciplining a resident for refusing. Information obtained during this screening is restricted to insure it is not used to exploit the resident.

### **Standard 115.242 Use of screening information**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Fulton CSC has a process in place that if an individual is determined to be at risk for sexual abuse or harassment or they are determined to be at risk to be a perpetrator they are strategically placed to give staff more visibility of them. The facility has not had any Transgender or Intersex residents. However, they have had Gay and Lesbian residents which they have taken steps to insure their safety if necessary.

### **Standard 115.251 Resident reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC educates all residents and staff on the multiple ways in which to report sexual harassment or abuse. These methods are covered during the resident's orientation as well as being provided in their handbook. This auditor also observed the posting throughout the facility on ways in which residents could report PREA issues. Residents also understood that they could report PREA issues while offsite. Line staff was able to articulate the process in which a resident could report abuse or harassment. In speaking with the residents of Fulton CSC they understood they could make a report of abuse or harassment by third party, the hotline, through staff both verbally and in writing and confidentially. Staff also were able to explain this process.

### **Standard 115.252 Exhaustion of administrative remedies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC has policy in place that covers all aspects of this standard. This auditor reviewed those policies and verified by interviewing the State PREA Coordinator, Unit Supervisor/PREA Coordinator and the facility's Director that in fact this is their process.

#### **Standard 115.253 Resident access to outside confidential support services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Residents at the Fulton CSC are given information on confidential support services outside of the facility. All staff and residents were able to explain where this information was located, i.e.: within their handbook and posted throughout the facility. Staff and residents also understood that this information would remain confidential unless the reporting party requested otherwise. While conducting the tour of the Fulton CSC I personally observed postings for resources that were outside the facility.

#### **Standard 115.254 Third-party reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC has policy which covers any action required when information is received concerning sexual abuse or harassment reported. All information is immediately documented and investigated. All staff interviewed at the Fulton CSC was able to explain this process. Missouri DOC has a website that allows third party reporting of sexual abuse or harassment. I personally observed postings of this website throughout the facility.

#### **Standard 115.261 Staff and agency reporting duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Staff at Fulton CSC understands that they are mandated by policy and statute that they are required to report any suspension or alleged sexual abuse or harassment of a resident. They also understand that failure to do so could result in being charged with a Class Misdemeanor. Although staff did not necessarily know the level of the charge they did know that criminal charges could be pressed. Staff explained that every twelve months they receive refresher training on the requirement to report. Staff also stated while being interviewed that once they report the information that they are not to discuss the information with anyone else after that, unless it is in conjunction with the investigation.

#### **Standard 115.262 Agency protection duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC and the Fulton CSC have policies in place that requires the facility to act should a resident be deemed in imminent danger for sexual abuse. That action includes protecting the individual by removing the offender to safe office while the information is investigated.

Documentation from the Fulton CSC states: The Fulton Community Supervision Center has had no incidents where a resident was deemed at substantial risk of imminent sexual abuse. If this were the case, the resident would be immediately moved to an area of the facility away from other residents, such as an interview room until appropriate actions could be taken to provide safe and appropriate housing.

#### **Standard 115.263 Reporting to other confinement facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC completes an incoming PREA Screening on all offenders entering the facility within twenty-four hours of their arrival. Part of that screening asks the resident if they were ever sexually abused or harassed at another facility. Fulton CSC has not had any reports of abuse or harassment at other facilities from their new arrivals. However they do have policy that outlines what the staff member is to do should that happen. Below is the excerpt of the policy which covers this:

Upon receiving information that an offender has been sexually abused while assigned at another facility the coordinated response for

offender sexual abuse will be immediately initiated as outlined in this procedure. If the alleged abuse occurred at a facility outside the Missouri Department of Corrections, the notification checklist will be forwarded to the department's PREA coordinator. The PREA coordinator will ensure notification to the facility is made with 72 hours.

#### **Standard 115.264 Staff first responder duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All staff interviewed stated as a first responder their first duty is to protect the victim and remove them to a safe location away from the accused. They also understood they were to protect the crime scene and evidence. This included securing any bedding, clothing, that could have been involved in the assault. They also stated that they were to keep the victim from showering, using the bathroom and brushing their teeth in order to protect any possible evidence. Staff was able to articulate that as soon as possible they would notify the Shift Commander.

#### **Standard 115.265 Coordinated response**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC has written policy and procedures on how to manage a coordinated response. Staff understands that if the allegation is a penetration incident and prior to 92 hours they are to preserve any evidence. They also understood the process should the allegation be past the 92 hours or a non-penetration incident.

#### **Standard 115.266 Preservation of ability to protect residents from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC Policy covers that no collective bargaining agreement will bar them from moving an alleged staff abuser from contact with any offender pending the outcome of the investigation. The Missouri DOC policy states:

F.

NEW AND/OR RENEWAL OF COLLECTIVE BARGAINING AGREEMENTS

1. Per the Prison Rape Elimination Act, the department shall not enter into or renew any collective bargaining agreements or other agreements that limit the department's ability to remove alleged staff sexual abusers from contact with any offender or resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

Below is section 2.2 of the collective bargaining agreement which also outlines the agency's ability to assign and reassign staff.

**Section 2.2**

These rights include, but are not limited to:

The right to determine its mission, policies, and to set forth standards and levels of service offered to the populations served;

The right to plan, direct, control, and determine the operation, and/or services to be carried out by its employees;

The right to determine the methods means, and number of staff needed to carry out its mission;

The right to direct the workforce;

The right to hire, assign, reassign, transfer, promote and to determine hours of work and shifts and assign overtime;

The right to suspend demote and dismiss in accordance with applicable statutes;

The right to furlough and lay off employees;

The right to make, publish, and enforce rules of personal conduct, procedures, policies, and regulations;

The right to introduce new methods of operation, equipment, or facilities;

The right to contract for goods and services;

And the right to exercise all powers and duties granted by law.

**Standard 115.267 Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The agency has written policy concerning the prohibition of retaliation against a staff member or resident for reporting any abuse of a resident.

**Standard 115.271 Criminal and administrative agency investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**



Fulton CSC utilizes the Fulton Prison Investigator Unit to investigate alleged sexual abuse and harassment. If substantiated those Investigators work with the local Prosecutors office for prosecution. I reviewed the list of available investigators trainings and verified they had all had specialized training in PREA investigations. An administrative investigation is also conducted during this process to determine if the alleged abuse was caused by neglect or failure to act by staff.

Fulton CSC had one resident who alleged they were abused while being transported on the facility van. While interviewing this resident they stated that the Fulton CSC staff were attentive to her needs and offered her outside assistance to include medical which they declined. The resident also stated the alleged abuser absconded after the abuse so it was not necessary to separate them. The resident also stated that staff followed up with them and checked on their wellbeing.

While interviewing the Unit Supervisor and District Administrator they stated they were aware of the allegation, however did not indicate if the incident was investigated. While reviewing the supporting documentation this auditor found that were no investigation referral forms provided for this incident or any others. After the writing of this report and upon review of the Fulton CSC staff and the State PREA Coordinator it was reported that this incident was in fact investigated by the IG's office and found unfounded. However the documentation provided to this auditor did not indicate the incident was referred for investigation. This auditor does believe that the facility did follow the guidelines just did not maintain the documentation. This is based on what the resident stated to this auditor.

#### **Standard 115.272 Evidentiary standard for administrative investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC and Fulton CSC has policy in place that states evidence necessary to determine if an allegation is substantiated which is "enough proof to show that something is more likely to have occurred than not to have occurred."

#### **Standard 115.273 Reporting to residents**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

After an allegation is made and the investigation is completed the resident is communicated in writing by the PREA Coordinator whether the allegation was substantiated, unsubstantiated or unfounded. Fulton CSC policy states:

- a. Upon the completion of a PREA investigation or inquiry regarding offender sexual abuse, the department's PREA coordinator shall make written notifications to the alleged victim regarding the outcome of the investigation or inquiry utilizing the applicable alleged sexual abuse by offender notification or the alleged sexual abuse by staff notification form.

- (1) Notification shall not be made to the offender following an investigation or inquiry regarding sexual harassment.
- b. The initial notification shall state whether the allegation was sustained, not sustained, or unfounded.

#### **Standard 115.276 Disciplinary sanctions for staff**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC's policy states:

##### **Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

##### **L. EMPLOYEE DISCIPLINE**

1. Staff members shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment procedures.
2. Termination from the department shall be the presumptive disciplinary action for staff members who have engaged in sexual abuse.
3. All terminations for violations or the resignation of a staff member, who would have been terminated if not for their resignation, shall be reported to relevant licensing or accreditation bodies and law enforcement.
4. Corrective action for contractors and volunteers:
  - a. Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement.
  - b. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations.

Fulton CSC has not had an allegation of sexual abuse or harassment against a staff member.

#### **Standard 115.277 Corrective action for contractors and volunteers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC has not had any sexual abuse allegations or harassment complaints against a contractor or volunteer. The policy states:

##### **Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

##### **4. Corrective action for contractors and volunteers:**

- a. Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement.

b. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations.

In interviewing the onsite PREA Coordinator, State PREA Coordinator and District Administrator they all stated that should an allegation be lodged against a volunteer or contractor, they would be removed from any contact with residents until the investigation was completed

**Standard 115.278 Disciplinary sanctions for residents**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC policy states that residents will not be disciplined when they report abuse or harassment in good faith. Should the allegation be substantiated the resident will be disciplined per policy, or if after being found guilty of sexual abuse in court discipline will be given. Staff stated that the abuser's mental disability or mental health was a contributing factor before imposing sanctions. Fulton CSC's policy states that the severity of the incident will be taken into account when determining what discipline will be given. Policy also states and staff confirmed that should a resident be found guilty of sexual abuse they will be referred to the appropriate treatment.

**Standard 115.282 Access to emergency medical and mental health services**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC does not have medical or mental health on staff or on contract.

**Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The onsite PREA Coordinator explained how services are provided should an allegation occur. This process was consistent to their policy

which is:

**Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

4. Corrective action for contractors and volunteers:
  - a. Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement.
  - b. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations.
17. Victims of sexual abuse shall be offered timely information and access to emergency contraception and sexually transmitted infections prophylaxis, in accordance with professionally accepted standards of care, where medically appropriate.
18. Treatment services shall be provided to the victim without financial cost and regardless of whether the victim names the abuser or cooperates with any investigation arising out of the incident.
19. Each victim and abuser shall be offered medical and mental health evaluation, and as appropriate, treatment and include appropriate follow-up services, treatment plans, and when necessary, referrals for continued care following their transfer to, or placement in, other facilities or their release from custody.
20. Victims and abusers shall be provided with medical and mental health services consistent with the community level of care in accordance with the institutional services procedures regarding medical and mental health services.
21. Victims of sexually abusive vaginal penetration while incarcerated shall be offered pregnancy tests.
22. If pregnancy results, the victim shall receive timely and comprehensive information about and timely access to all lawful pregnancy-related medical services.

**Standard 115.286 Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

When talking with the onsite PREA Coordinator and District Administrator they were a little confused as to what the Sexual abuse incident review was since they do not have medical staff or mental health staff. After probing concerning what happens after an allegation is either substantiated or unsubstantiated they understood that yes there is a review after an allegation that includes the investigator, upper management and security. They also understood that should mental health providers or medical services be provided that they would also be involved in the review.

**Standard 115.287 Data collection**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC provides an annual report to the state PREA Coordinator that includes the number of allegations if any, whether they substantiated, unsubstantiated or unfounded. They also report on any improvements or needs of the facility. This report is then compiled by the state PREA Coordinator and posted on the Missouri DOC's website.

### Standard 115.288 Data review for corrective action

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Fulton CSC provides an annual report to the state PREA Coordinator that includes needs of improvement to the facility, how to better detect abuse and harassment etc.

### Standard 115.289 Data storage, publication, and destruction

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The state PREA Coordinator compiles all reports from all Missouri CSC facilities and provides that on the Missouri DOC website.

### AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Lynn S. Guyer

September 1, 2015

Auditor Signature

Date

**REA AUDIT REPORT   ☐ Interim   ☒ Final**

**COMMUNITY CONFINEMENT FACILITIES**

**Date of report:** September 23, 2015

<b>Auditor Information</b>			
<b>Auditor name:</b> Lynn S. Guyer			
<b>Address:</b> P.O. Box 86 Cottonwood, Idaho 83522			
<b>Email:</b> lguyer@q.com			
<b>Telephone number:</b> 208-451-6535			
<b>Date of facility visit:</b> August 13, 2015			
<b>Facility Information</b>			
<b>Facility name:</b> Hannibal Community Release Center			
<b>Facility physical address:</b> 2002 Warren Barrett Drive, Hannibal, Mo. 63401			
<b>Facility mailing address:</b> <i>(if different from above)</i> N/A			
<b>Facility telephone number:</b> 573-248-2450			
<b>The facility is:</b>	<input type="checkbox"/> Federal	<input type="checkbox"/> State	<input type="checkbox"/> County
	<input type="checkbox"/> Military	<input type="checkbox"/> Municipal	<input type="checkbox"/> Private for profit
	<input type="checkbox"/> Private not for profit		
<b>Facility type:</b>	<input type="checkbox"/> Community treatment center	<input checked="" type="checkbox"/> Community-based confinement facility	
	<input type="checkbox"/> Halfway house	<input type="checkbox"/> Mental health facility	
	<input type="checkbox"/> Alcohol or drug rehabilitation center	<input type="checkbox"/> Other	
<b>Name of facility's Chief Executive Officer:</b> Kevin Knickerbocker			
<b>Number of staff assigned to the facility in the last 12 months:</b> 44			
<b>Designed facility capacity:</b> 30-50			
<b>Current population of facility:</b> 27			
<b>Facility security levels/inmate custody levels:</b> Field Supervision Clients			
<b>Age range of the population:</b> 18 plus			
<b>Name of PREA Compliance Manager:</b>		<b>Title:</b> Unit Supervisor/PREA Coordinator	
<b>Email address:</b> <a href="#">Click here to enter text.</a>		<b>Telephone number:</b> 573-248-2450	
<b>Agency Information</b>			
<b>Name of agency:</b> Hannibal Community Release Center			
<b>Governing authority or parent agency:</b> <i>(if applicable)</i> Missouri Department of Corrections			
<b>Physical address:</b> 2729 Plaza Drive, Jefferson City, Mo. 65102			
<b>Mailing address:</b> <i>(if different from above)</i> Same			
<b>Telephone number:</b> 573-751-2389			
<b>Agency Chief Executive Officer</b>			
<b>Name:</b> George Lombardi		<b>Title:</b> Director	
<b>Email address:</b> George.lombardi@doc.mo.gov		<b>Telephone number:</b> 573-526-6607	
<b>Agency-Wide PREA Coordinator</b>			
<b>Name:</b> Vivia Sturm		<b>Title:</b> PREA Coordinator	
<b>Email address:</b> vivia.sturm@doc.mo.gov		<b>Telephone number:</b> 573-522-3335	

## **AUDIT FINDINGS**

### **NARRATIVE**

The Hannibal CSC is well run and clean facility. Staff are very professional and knowledgeable on their job duties and PREA requirements. Upon arriving at Hannibal CSC I met with the facility District Administrator, Unit Supervisor/PREA Coordinator and the state PREA Coordinator for an initial briefing. We covered the days schedule and who I would be interviewing. We then toured the facility. During the tour I was looking for camera placement, inmate living areas, blind spots, PREA postings, etc. I found the facility to have excellent security camera placement, PREA postings and staff visibility of residents. One area in the male restroom area has a major blind spot with was due to facility design. The facility grated this area off to deny access to residents and it is now used as storage.



## **DESCRIPTION OF FACILITY CHARACTERISTICS**

Hannibal CSC is a co-ed facility with the male and female residents separated. The living areas are open and visible by staff from the control center. The facility also has multiple security cameras that allow the Hannibal staff to see the entire facility from the control center. Residents at Hannibal CSC are Missouri Department of Corrections' parolees and probationers awaiting their home plan approval, probation violators and parolees and probationers without home plans. The majority of the offenders are in the community during day completing job search, attending programming/treatment, home search or working. Residents are transported to these activities by staff at the facility.

## SUMMARY OF AUDIT FINDINGS

I found the Hannibal CSC to be very proficient in the PREA audit standards. Staff and residents both understood their responsibility for insuring the residents were protected from sexual abuse or harassment. Throughout the facility PREA announcements are posted so that residents understand how to report any abuse or harassment. Unit Supervisor/PREA Coordinator Jill Perry has developed a checklist for when a report of abuse or harassment is reported. The document is so thorough that a person not affiliated with the facility could walk through the process contacting the proper medical, mental health and investigative personnel. It also explains what actions are to be taken with the victim and how to protect the evidence, and dealing with the suspect. I would suggest this document be used with every Community Supervision Center.

The Unit Supervisor/PREA Coordinator has announced her upcoming retirement this next year. This will be a major knowledge loss for the facility. In speaking with the District Administrator and the Unit Supervisor they have a plan in place to hire a new onsite PREA Coordinator prior to Ms. Perry's departure to allow them to be cross trained.

Number of standards exceeded: 6

Number of standards met: 33

Number of standards not met: [Click here to enter text.](#)

Number of standards not applicable: [Click here to enter text.](#)

### Standard 115.211 Zero tolerance of sexual abuse and sexual harassment; PREA Coordinator

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC has written policy that mandates zero tolerance to sexual abuse or harassment of offenders/residents in their custody. This includes the agency having a statewide PREA Coordinator. While interviewing the statewide PREA Coordinator Vivian Sturm she stated that she did have enough time to complete her duties. The Hannibal also has an onsite PREA Coordinator that deals with the day to day issues, and insuring staff are trained.

### Standard 115.212 Contracting with other entities for the confinement of residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Hannibal CSC and Missouri Department of Corrections does not have any contracted beds.

**Standard 115.213 Supervision and monitoring**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Hannibal CSC staffing plan includes having at least one female on duty at all times. The policy staffing plan is to have two staff on duty at any given time. Hannibal staffing plan exceeds that policy and more. It also includes at least one female staff on duty at all times. This goes beyond the department's policy requirement. Hannibal CSC provided me with their staffing plan which included maintaining three staff with one of those being female at all times. While interview the Unit Supervisor/PREA Coordinator she stated that the staffing plan includes an alternative schedule so that shifts overlap to allow more coverage with female staff. While interviewing the District Administrator he stated that at any time there is a deviation from the staffing pattern that is to be staffed with the duty officer and onsite PREA Coordinator. During my interviews with the District Administrator and the onsite PREA Coordinator they stated that the facility has not had the necessity to deviate from the staffing plan.

**Standard 115.215 Limits to cross-gender viewing and searches**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC has written policy concerning cross-gender viewing and searches. Because they have 50 residents or less they do not fall under this standard, however they have in place that if a cross-gender pat or strip search is conducted it is documented. I reviewed those documents and found no instances where staff found it necessary to conduct cross-gender searches. The policy also states that under no circumstances are strip searches to be conducted to determine the genital status of the resident. While interviewing residents they stated that at no time were they ever subjected to strip searches to determine their genital status. Residents also stated that they had not been pat searched by the opposite gender.

**Standard 115.216 Residents with disabilities and residents who are limited English proficient**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has not had any residents with disabilities or limited English proficient, however the Missouri DOC's policy states:

6. Offender Education:
  - a. The department shall provide PREA related education in formats accessible to all offenders, including those who are limited English proficient, deaf, visually impaired, or otherwise disabled, as well as to offenders who have limited reading skills in accordance with the department's procedures regarding deaf and hard of hearing offenders, disabled offenders, and blind and visually impaired offenders.
    - (1) Offenders who have limited English proficiency shall be provided a copy of the video transcript and the PREA offender brochure in their native language.
      - (A) If these documents are not already translated as a recognized language by the department, the department shall make reasonable accommodations to provide these documents in the offender's native language.
      - (B) If the documents are unable to be translated in the offender's native language the department's PREA site coordinator or designee shall utilize an interpreter to assist the offender in understanding the information provided.
  - b. The PREA site coordinator shall be make key information readily available or visible to all offenders through the PREA posters, the offender rulebook, and the offender brochure on sexual abuse and harassment

#### **Standard 115.217 Hiring and promotion decisions**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC requires that all new hires complete a background questionnaire. They also require that if the individual has been employed in a different correctional facility that a PREA check list be completed. The check list includes whether the new recruit has ever been terminated or otherwise disciplined or counseled for sexual contact with or sexual harassment of an inmate, detainee or resident of the facility. Missouri DOC policy also states concerning promotions that:

4. Prior to approval of a promotional appointment, regardless of the salary range, a check will be conducted of the employee's official personnel file through central office human resources. This check will be performed to ensure the employee has received no formal discipline for sustained allegations of sexual abuse and/or harassment or any information indicating any pending or adjudicated criminal charges. All sustained allegations will be considered by the department before an employee is promoted.

#### **Standard 115.218 Upgrades to facilities and technologies**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The only upgrade to the Hannibal CSC was to grate off an area in the men's restroom area. A facility design flaw placed a blind area in the bathroom. The facility closed that area off and now uses it for storage.

#### **Standard 115.221 Evidence protocol and forensic medical examinations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All Hannibal uniform staff have been trained in protocol for protecting and obtaining evidence. Staff interviewed also stated and I verified through training records that they are trained again annually.

#### **Standard 115.222 Policies to ensure referrals of allegations for investigations**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC has a written policy that includes all PREA allegations are referred for investigation unless it is determined that no criminal behavior existed. These policies are posted on the Missouri DOC website. The Hannibal CSC has a written procedure that walks the staff through how to react to a PREA allegation. As I stated to the District Administrator, Unit Supervisor and the State PREA Coordinator this documents is so easy to follow that even someone who has no understanding of what is available in Hannibal they would be able to go step by step completing all referrals of allegations for investigations.

#### **Standard 115.231 Employee training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance**

**determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC policy requires all new and existing staff receive training concerning Zero Tolerance and PREA reporting. While conducting interviews in the break room at Hannibal, I observed a computer that had the PREA training loaded on it. In reviewing Missouri DOC's supporting the documentation Director Lombardi has a mandate that requires all staff, contractors and volunteers to receive training in the Zero Tolerance for sexual abuse/harassment. Also in that mandate it stated that due to budget constraints a booklet formerly issued to staff, volunteers and contractors was no longer fiscally feasible and was now computer training. This also allows the agency to ensure the individual has reviewed this information. Below is the policy requiring staff training:

4. PREA Training:

- a. All new staff members shall complete the department's online sexual misconduct and harassment training within 5 days of employment.
- b. All staff members shall receive initial PREA training during the department's basic training.
- c. All staff members shall complete refresher training every two years to ensure knowledge of the agency's current sexual abuse and sexual harassment procedures.
- d. Years in which an employee does not receive training, the department's PREA coordinator shall provide current information on sexual abuse and sexual harassment policies

**Standard 115.232 Volunteer and contractor training**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While reviewing the supporting documentation from Hannibal CSC and Missouri DOC requires volunteers, contractors and part-time staff to complete training on PREA. This was also confirmed while interviewing the District Administrator, Unit Supervisor and State PREA Coordinator. I also reviewed training documents showing that these individuals do indeed receive this training. The Hannibal policy states:

- e. Part-time Employees/Volunteers/Contract Staff Members/Vendors:
- (1) All part-time employees, volunteers and contract staff members shall receive PREA specific training to their classification as determined by the appropriate division director and chief of staff training.
  - (2) Vendor contractors shall be escorted by a staff member at all times or shall receive PREA training prior to entering the facility.
  - (3) Contracted residential facilities shall ensure all staff are trained on PREA as outlined in the residential contract.

**Standard 115.233 Resident education**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)

- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

During my review of supporting documents from Hannibal CSC they show that all residents receive within the first twenty-four hours education on their right to be free from sexual abuse and harassment. The training also includes how they can report this information. I personally observed throughout the facility fliers that were posted explaining to the residents their right to be free from sexual abuse and harassment and how they report any abuse or harassment. While interviewing staff and residents I confirmed that this education is presented within the first twenty-four hours as well as every morning a PREA announcement is made through the intercom system. All residents also review a video as part of this education which because of the facility size is not required under the PREA standard.

#### **Standard 115.234 Specialized training: Investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All Missouri DOC investigators have received specialized training concerning Prison Rape. They have also received training concerning Garrity and Miranda warnings. This information was verified through the training records provided by Hannibal CSC and the Missouri DOC policy. Missouri DOC policy concerning investigators states:

b. All new investigator and administrative inquiry officers (AIOs) or designees assigned to investigate offender sexual abuse allegations shall receive specialized PREA training by the designated inspector general's office staff members.

#### **Standard 115.235 Specialized training: Medical and mental health care**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC does not employ or contract mental health or medical services. They do, however, have community providers that both adhere to SANE/SAFE standards.



### Standard 115.241 Screening for risk of victimization and abusiveness

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Every resident that enters the Hannibal CSC received a screening to determine their risk of victimization and abusiveness. This screening is conducted within the first twenty-four hours, however in interviewing staff and residents they all indicated that the screening was conducted shortly after arriving at the facility. The standard requires that the resident be assessed within the first seventy-two hours. All residents interviewed stated that they were asked if they had ever been a victim of sexual abuse or harassment. The screening also ask the resident what their perception of vulnerability is. Even though no resident indicated they refused to participate in the assessment they all understood that they would not be disciplined for refuse. Staff also stated during the interviews that residents would not be punished for refusing to answer question. While conducting interviews of the Hannibal CSC staff they stated that the screening instrument is confidential to assure the resident is not targeted. The Hannibal CSC policy states:

2. The client shall be assessed utilizing the [Risk of Victimization and Abusiveness Screening Tool form](#) (Attachment C) to identify those at risk for being sexually abusive or sexually abused.
  - a. The initial screening shall be completed within 72 hours of the client's arrival at the CSC.

**\*\*SOP Addition:** The initial screening will be completed by a PPA staff member during Intake, which is completed immediately upon arrival of the resident. Bed assignment will be determined based upon the Risk of Victimization and Abusiveness Assessment, as noted in P 4.24 Housing Assignments. The screening tool will be placed in the CSC file and a copy will be forwarded to the PREA Site Coordinator.
  - b. Clients will be reassessed utilizing the [Risk of Victimization and Abusiveness Screening Tool form](#) (Attachment C) within 30 days from the date of initial assessment and at any other time when warranted based upon the receipt of additional relevant information or following an incident of abuse or victimization.

**\*\*SOP Addition:** The supervising Probation/Parole Officer will be responsible to complete the Risk of Victimization and Abusiveness Assessment within thirty days of assignment to the facility. The original will be sent to the PREA Site Coordinator, who will ensure it is placed in the CSC file, a copy placed in the PREA Site Coordinator file and that the bed assignment is adjusted, if necessary.
  - c. Staff must inform clients before they begin the screening that they are not required to answer any of the questions.
  - d. Clients shall not be disciplined for refusing to answer or for not disclosing complete information in response to questions asked on the screening form.

### Standard 115.242 Use of screening information

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC uses the screening information to insure that potentially abusive residents are separated from vulnerable residents. In the living areas the possible aggressive resident is placed away from the possible vulnerable resident. More visibility is given to those residents to be considered at risk. When facility job assignments are given the facility utilizes the screening tool to insure residents that are considered to vulnerable are not assigned with those that are considered at risk to be aggressive. Hannibal CSC has not had any residents who were transgender or intersex assigned to the facility. The facility does not isolate residents who are gay or lesbian. While interviewing staff and residents they both indicated that after thirty days they were asked the screening questions again.

#### **Standard 115.251 Resident reporting**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing both staff and residents at Hannibal CSC they understood the multiple ways in which reporting of sexual abuse/harassment could be completed. Throughout the facility I observed fliers posted that explained how residents could report abuse or harassment. Because the Hannibal CSC residents are consistently off site residents and staff stated they could report abuse or harassment in a multiple of ways. They can tell their employer, counselor, family member or call law enforcement to name a few.

While interviewing staff they understood that they could take reports directly from the resident, anonymously or through other sources. They also stated that upon receiving any information they would immediately document and start the PREA assessment process.

While interviewing staff they at first were unsure on how to report allegations privately. As they were interviewed they were able to articulate how they could report allegations privately. This may be something the agency may want to consider educating their staff on. Below is an excerpt of the Hannibal policy concerning reporting of harassment or abuse.

#### **D. REPORTING SEXUAL ABUSE OR HARASSMENT**

1. Each facility's CAO or designee shall provide multiple ways for offenders to make anonymous reports of allegations of offender sexual abuse and harassment, retaliation, staff neglect, and violation of responsibilities that may have contributed to an incident of offender sexual abuse, to include but not be limited to:
  - a. informal resolution request (IRR), grievance process, or offender complaint,
  - b. to a staff member,
  - c. PREA hotline,
  - d. advocacy agency,
  - e. Department of Public Safety, Crimes Victims Services Unit
2. All allegations including anonymous, third party, verbal, or allegations made in writing shall be accepted and moved forward in accordance with the offender sexual abuse coordinated response outlined in this procedure

### Standard 115.252 Exhaustion of administrative remedies

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While reviewing supporting documentation from Hannibal CSC and conducting interviews of staff, it was apparent that the agency has policy that guides the use of administrative remedies for residents to file grievances concerning sexual abuse and harassment. Below is an excerpt of that policy:

8. Offender Sexual Abuse and Harassment Complaint Appeals
  - a. Upon receipt of a sexual misconduct complaint response, the client shall review and indicate whether the response is accepted or appealed.
  - b. The client's response should clearly state the reason for appeal, and shall be returned to the client within seven calendar days.
  - c. The client may receive assistance from a third party when filing requests for remedies related to sexual abuse which includes permitting the third party to file the request on behalf of the client.
    - 1) The client shall agree to have the request submitted on his behalf.
    - 2) If the client agrees to have the request submitted by a third party the client shall be required to pursue the appeals process.
  - d. The CAO/designee shall forward the appeal to the RA.
  - e. Upon receipt, the RA has 30 days to provide a response to the client's appeal.
  - f. An extension of up to 70 days may be allowed for the response to be provided.
    - 1) The client shall be notified in writing of any such extension, and
    - 2) The client shall be given a date by which a response should be provided.
  - g. If the client does not receive a response within the time allotted at any level of the administrative process, including the final level and including the allowed extension, then the client may consider the absence of a response to be a denial at that level.

### Standard 115.253 Resident access to outside confidential support services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While touring the Hannibal CSC I observed numerous areas where the PREA hotline was posted. There is also information contained within the resident handbook which instructs the residents how they report incidents of sexual abuse or harassment privately. While interviewing both staff and residents they both stated and gave examples of how the resident can report any issues of sexual abuse or harassment privately.

### Standard 115.254 Third-party reporting

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC policy describes how residents can have a third party report any incidents of harassment or abuse. Residents stated during their interviews that they understood they could use the PREA hotline, have a family member, employer etc. report any incidents of abuse or harassment to the facility or department for investigation. One resident interviewed stated while incarcerated at another facility they had their spouse report and incident of sexual abuse that the resident had observed. They felt this route was better and kept their name out of the investigation thus protecting them. Throughout the facility and in the reception area there are posting explaining how individuals can report incidents of sexual abuse or harassment through third party.

### Standard 115.261 Staff and agency reporting duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Missouri DOC has policy in place which requires all staff to report any sexual abuse or harassment of offenders. Missouri State Statute also makes it a class A misdemeanor for failure to report. While interviewing staff at the Hannibal CSC they all stated that there is policy that requires them to report any incident and that failure to do so would result in disciplinary actions and possible criminal actions. Below is an excerpt from the policy requiring reporting:

Failure to report offender sexual abuse is a class A misdemeanor. All staff members, volunteers, and contractors shall immediately report any knowledge, suspicion, or information regarding an incident of sexual abuse or sexual harassment that occurred in a facility and any knowledge of retaliation against offenders or staff members who reported such an incident and any staff member neglect or violation of responsibilities that may have contributed to an incident or retaliation in accordance with this procedure.

### Standard 115.262 Agency protection duties

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing staff at Hannibal CSC they all understood that if during the initial screening or when new information comes forward that a resident is at substantial risk for abuse the facility takes immediate action to insure the resident is safe. If a resident is deemed at risk for abuse they are strategically placed in the living unit to allow more visibility for staff. They are also placed away from where those that are more likely to be abusers. Supporting documentation states:

The Hannibal Community Supervision Center in situations where a resident was deemed at substantial risk of imminent sexual abuse, the resident would be immediately moved to an area of the facility away from other residents, such as an interview room until appropriate actions could be taken to provide safe and appropriate housing

#### **Standard 115.263 Reporting to other confinement facilities**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While reviewing supporting documentation from Hannibal CSC I was able to ascertain from the intake screening documents that all new residents are asked if they were abused or harassed at another facility, it was also found that no residents reported that they had been abused at any other facility. Missouri DOC does have policy in place that should a resident disclose that they were abused at a different facility, the facility is required to contact that facility. Hannibal CSC Field Memorandum states:

Upon learning of resident upon resident sexual abuse while confined at another facility, an email with details of the event would be sent asap to the department PREA coordinator with any information gathered.

#### **Standard 115.264 Staff first responder duties**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing staff at Hannibal CSC they all stated they have been trained in first responder duties. I was also able to verify this information through training documentations. All staff stated their first and foremost responsibility was to insure the safety of the victim and separate them from the abuser. Staff also were able to explain their responsibility depending on if the incident was a penetration incident or non-penetration. Below is an excerpt from the Hannibal CSC policy concerning first responder:

- b. Staff member first responder shall:
  - (1) Ensure the safety of the victim.
  - (2) Request the victim not to take any actions that may destroy physical evidence including washing, brushing teeth, changing clothes, urinating, defecating, smoking, drinking, or eating, when applicable.
  - (3) Make immediate notification to the shift commander or shift supervisor.
    - (A) In the event of an allegation of a penetration act, the shift commander or shift supervisor shall make telephone notifications and respond as outlined in the divisions' coordinated response to offender sexual abuse protocol.
    - (B) In the event of a non-penetration or harassment event the shift commander or shift supervisor shall make email notifications as outlined in the applicable PREA notification checklist protocol.

#### **Standard 115.265 Coordinated response**

- ☒ Exceeds Standard (substantially exceeds requirement of standard)
- ☐ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC does not have Medical or Mental Health providers on site. They do have local providers that are SANE/SAFE to provide services to residents who have been a victim of sexual abuse. Hannibal CSC has one of the best coordinated response document that this auditor has seen. This document provides a step by step process that staff can follow that includes taking care of the victim, referrals, notifications, and processing the crime scene. The document is so well written that someone that is not familiar with the process could walk through it. All security staff that I interviewed understood this process and knew where to obtain the document discussed above.

#### **Standard 115.266 Preservation of ability to protect residents from contact with abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri DOC policy and the Collective Bargaining agreement with the PPA Union allows Missouri DOC to place staff where needed without restriction. Below is an excerpt from the Missouri DOC policy:

**F. NEW AND/OR RENEWAL OF COLLECTIVE BARGAINING AGREEMENTS**

1. Per the Prison Rape Elimination Act, the department shall not enter into or renew any collective bargaining agreements or other agreements that limit the department's ability to remove alleged staff sexual abusers from contact with any offender or resident pending the outcome of an investigation or of a determination of whether and to what extent discipline is warranted.

**Standard 115.267 Agency protection against retaliation**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

While interviewing both staff and residents they all stated that they were protected from retaliation from reporting sexual abuse or harassment. There have been no reported incidents of sexual abuse or harassment at Hannibal CSC. While interviewing the Unit Supervisor and the state PREA Coordinator they both stated that should an allegation come forward the staff member or resident who reported it would be protected from retaliation. They also state that the resident or staff member would be monitored to insure that no retaliation resulted because of the report. Below is an excerpt from the Missouri DOC policy concerning retaliation:

**Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

8. Protection Against Retaliation:
  - a. The PREA site coordinator shall ensure all victims and reporters and those that cooperate with offender sexual abuse and harassment investigations or inquiries are monitored and protected from retaliation.
  - b. Immediately following any reported incident of sexual abuse or harassment, monitoring for retaliation shall be conducted in the following manner:
    - (1) The alleged victim and reporter of offender sexual abuse or harassment shall be monitored for a minimum of 90 days to assess any potential risk or act of retaliation.
      - (A) For offender victims and offender reporters, monitoring shall include face-to-face status checks by staff members a minimum of every 30 days.
      - (B) The assessment/retaliation status check form shall be used during each of the assessment interviews.
      - (C) If the victim or reporter expresses fear of retaliation, monitoring shall continue for an additional 90 day period or until the victim or reporter is no longer in fear of retaliation or if the investigation or inquiry is unfounded.
    - (2) The PREA site coordinator or designee shall monitor all staff reporters of offender sexual abuse or harassment for a minimum of 90 days. Monitoring shall include but is not limited to monitoring for changes that may indicate retaliation, negative performance reviews, or reassignments.
      - (A) The assessment/retaliation status check form shall be used during each of the assessment interviews.
    - (3) The PREA site coordinator or designee shall ensure all witnesses receive an initial assessment utilizing the assessment/retaliation status check form.
      - (A) Witnesses who voice they have no concerns regarding potential retaliation shall not receive further monitoring.
      - (B) The witness shall sign the assessment/retaliation status check form showing they have no concerns regarding



potential retaliation.

- c. The PREA site coordinator shall report all evidence of retaliation to the CAO to ensure an inquiry or investigation is initiated in accordance with department procedures.
- d. If possible retaliation is suggested, the PREA site coordinator shall act promptly to remedy any such retaliation and protect the individual.
- e. The PREA site coordinator shall ensure victims, reporters, and witnesses that report a fear of retaliation and/or possible victims of retaliation be offered emotional support services.
  - (1) Emotional services for offender victim, reporters, or witnesses include but are not limited to, case management or referral to mental health, chaplain, or advocacy when appropriate.
  - (2) Emotional services for staff reporters or witnesses included but are not limited to, employee assistance program, peer action and care team referral, and/or chaplain referral.
  - (3) All action taken to remedy retaliation or services offered victim or suspected victim shall be noted on the assessment/retaliation status check form.
- f. In the event that a victim, offender reporter, or a witness is transferred during a period of monitoring, the PREA site coordinator shall forward the assessment/retaliation status check form to the PREA site coordinator in the receiving institution.
  - (1) The PREA site coordinator at the receiving institution shall ensure monitoring continues as outlined in this procedure.
  - (2) The PREA site coordinator shall ensure the completed assessment/retaliation status check form is returned to the originating institution to be filed in the PREA incident file for future audits.
- g. In the event the allegations are determined to be unfounded the agency shall terminate monitoring.

#### **Standard 115.271 Criminal and administrative agency investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC utilizes Missouri DOC investigators to investigate any accusations of sexual abuse or harassment against a resident. All Missouri DOC investigators have received specialized training in conducting PREA investigations. This information was verified by training records provided by Hannibal CSC. Hannibal CSC has had no allegations of sexual abuse or harassment at their facility either through residents, staff or third party.

#### **Standard 115.272 Evidentiary standard for administrative investigations**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Missouri's DOC policy states: T. **Preponderance of Evidence:** Enough proof to show that something is more likely to have occurred than not to have occurred.

This is the level of proof needed to determine whether an allegation of sexual abuse or harassment is substantiated.

### Standard 115.273 Reporting to residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

The Hannibal CSC has had no allegations of sexual abuse or harassment. In reviewing the Hannibal CSC supporting documentation they provided an excerpt from the Missouri DOC policy which states:

Excerpt D1-8.13 Offender Sexual Abuse and Harassment

5. Reporting Outcomes:
  - a. Upon the completion of a PREA investigation or inquiry regarding offender sexual abuse, the department's PREA coordinator shall make written notifications to the alleged victim regarding the outcome of the investigation or inquiry utilizing the applicable alleged sexual abuse by offender notification or the alleged sexual abuse by staff notification form.
    - (1) Notification shall not be made to the offender following an investigation or inquiry regarding sexual harassment.
  - b. The initial notification shall state whether the allegation was sustained, not sustained, or unfounded.
  - c. In the event that the investigation was conducted by an outside agency, the office of the inspector general shall request relevant information from the outside agency in order to inform the offender of the outcome of the investigation.
  - d. All subsequent notifications shall be made when:
    - (1) Staff member on offender allegations: following the completion of an inquiry or investigation, the offender shall be notified when the following occurs unless the inquiry or investigation is unfounded:
      - (A) Staff perpetrator is no longer assigned to the housing unit.
      - (B) Staff perpetrator is no longer employed at the institution or department.
      - (C) The staff perpetrator has been indicted on a charge related to sexual abuse within the institution.
      - (D) A disposition of charges exists related to sexual abuse within the institution.
    - (2) Offender on offender allegations: following the completion of an inquiry or investigation, the offender shall be notified when the following occurs.
      - (A) The offender has been indicted on a charge related to sexual abuse within the institution.
      - (B) A disposition of charges exists related to sexual abuse within the institution.
  - e. The departmental PREA coordinator shall forward the written notification to the offender via the PREA site coordinator.
    - (1) The PREA site coordinator shall ensure that the written notification is provided to the offender.
      - (A) If the investigation or inquiry involved offender-on-offender sexual abuse or harassment that was sustained or not sustained, written notification shall be delivered to the offender victim in a confidential manner.
      - (B) The offender shall be offered the notification letter but shall have the right to decline the letter.
    - (2) The original notification shall be signed by the offender or resident and witnessed by a staff member.
    - (3) The original notification shall be forwarded to the department's PREA coordinator for tracking.
    - (4) A copy of the notification shall be provided to the offender.
    - (5) The date the notification letter is delivered to the offender shall be documented in the chronological section of the offender's classification file.
    - (6) In the event the offender is no longer housed in an institution, community release center, or community supervision center the duty to report ends.

Both the Unit Supervisor and state PREA Coordinator verified that this is the procedure followed when there is an allegation.

### Standard 115.276 Disciplinary sanctions for staff

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegation against staff concerning sexual abuse or harassment of residents. Missouri DOC policy states:

#### **Excerpt D1-8.13 Offender Sexual Abuse and Harassment**

##### **L. EMPLOYEE DISCIPLINE**

1. Staff members shall be subject to disciplinary sanctions up to and including termination for violating agency sexual abuse and sexual harassment procedures.
2. Termination from the department shall be the presumptive disciplinary action for staff members who have engaged in sexual abuse.
3. All terminations for violations or the resignation of a staff member who would have been terminated if not for their resignation, shall be reported to relevant licensing or accreditation bodies and law enforcement.

### Standard 115.277 Corrective action for contractors and volunteers

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegations against contractors or volunteers pertaining to sexual abuse or harassment. While interviewing the District Administrator, Unit Supervisor and state PREA Coordinator they all stated that should an allegation be lodged that the contractor or volunteer would immediately be removed from the facility and no longer allowed contact with the residents pending the outcome of the investigation. Missouri DOC policy states in part:

4. Corrective action for contractors and volunteers:
  - a. Contractors or volunteers who engage in sexual abuse shall be prohibited from contact with offenders and shall be reported to relevant licensing bodies and law enforcement.
  - b. The CAO or designee of the department facility or contracted facility shall take appropriate measures and shall consider whether to prohibit further contact with offenders in the case of any other violations.

## Standard 115.278 Disciplinary sanctions for residents

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegations or investigations concerning sexual abuse or harassment at the facility. Missouri DOC policy states:

### Excerpt D1-8.13 Offender Sexual Abuse and Harassment

#### K. VIOLATIONS OR DISCIPLINARY SANCTIONS FOR OFFENDERS

1. Offenders shall be subject to disciplinary sanctions or violations pursuant to a formal disciplinary process following an administrative finding or a criminal finding of guilt when the offender engaged in offender on offender sexual abuse in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.
2. Sanctions shall be commensurate with the nature and circumstances of the abuse committed, the offender's disciplinary history, and the sanctions imposed for comparable offenses by other offenders with similar histories in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.
3. The disciplinary process shall consider whether an offender's mental disabilities or mental illness contributed to his behavior when determining what type of sanction, if any, shall be imposed in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.
4. If found guilty of sexual abuse, the offender shall be referred to appropriate treatment (therapy, counseling) by mental health staff member, as available, in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.
5. An offender who has sexual contact with a staff member may only be disciplined if the staff member did not consent to the contact in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.
6. The department prohibits all sexual activity between offenders. Consensual sexual activity between offenders will not be deemed sexual abuse and shall be addressed in accordance with divisional and institutional services procedures regarding conduct violations and disciplinary sanctions.

## Standard 115.282 Access to emergency medical and mental health services

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has no medical or mental health providers onsite. They do however have local agencies that are SANE/SAFE providers. These services are provided at no cost to the resident.

### **Standard 115.283 Ongoing medical and mental health care for sexual abuse victims and abusers**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegations of sexual abuse or harassment at their facility.

### **Standard 115.286 Sexual abuse incident reviews**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegations of sexual abuse or harassment to require an incident review. However should an incident occur it was verified that the incident review would include the District Administrator, Unit Supervisor, state PREA Coordinator, security staff, mental health and medical providers.

### **Standard 115.287 Data collection**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Hannibal CSC has had no allegations of sexual abuse or harassment. Annually the facility completes a report on any allegations and corrective action if needed. This information is then posted on the Missouri DOC website.

### **Standard 115.288 Data review for corrective action**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

Even though Hannibal CSC has not had any sexual abuse or harassment allegations they still include in their annual report upgrades in the facility that would assist in better improving their elimination of sexual abuse or harassment.

#### **Standard 115.289 Data storage, publication, and destruction**

- ☐ Exceeds Standard (substantially exceeds requirement of standard)
- ☒ Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period)
- ☐ Does Not Meet Standard (requires corrective action)

**Auditor discussion, including the evidence relied upon in making the compliance or non-compliance determination, the auditor's analysis and reasoning, and the auditor's conclusions. This discussion must also include corrective action recommendations where the facility does not meet standard. These recommendations must be included in the Final Report, accompanied by information on specific corrective actions taken by the facility.**

All Missouri DOC facilities complete an annual report that indicates any sexual abuse/harassment complaints that were reported; whether they were substantiated, unsubstantiated or unfounded and corrective action taken. This information is then compiled and posted on the Missouri DOC public website. Below is Missouri DOC policy that covers the collection and publication of this information:

#### **M. ANNUAL REPORTS**

1. Annual Site Report: Each facility shall utilize information from the offender sexual abuse debriefings to prepare an annual report to be submitted to the department's PREA coordinator by the last working day in March.
  - a. The report shall include:
    - (1) identified problem areas,
    - (2) recommendations for improvement,
    - (3) corrective action taken,
    - (4) if recommendations for improvements were not implemented, reasons for not doing so,
    - (5) a comparison of the current year's data and corrective actions with those from prior years, and an assessment of the facilities' progress in addressing sexual abuse,
    - (6) an evaluation of the need for camera and monitoring systems,
    - (7) in consultation with the PREA site coordinator; assessment, determination, and documentation of whether adjustments are needed to:
      - (A) the staffing plan,
      - (B) the deployment of video monitors, and
      - (C) the resource availability to adhere to the staffing plan.
  - b. The yearly report shall be submitted to the division director and the department PREA coordinator no later than the last working day in March.
2. Agency Report: The PREA coordinator shall prepare an annual report compiling each facility's current year's data and corrective actions.
  - a. The report shall include:
    - (1) a comparison with prior year's data,

- (2) corrective actions, and
  - (3) an assessment of the department's progress in addressing offender sexual abuse,
- b. The report shall be forwarded to the department director for approval by the last working day in May.
- c. The CAO or designee, PREA coordinator, and/or department director shall edit specific material from the reports when publication would present clear and specific threat to the safety and security of the facility.
  - (1) The CAO or designee, PREA coordinator, and/or department director shall indicate the nature of the material edited.
- d. The department's annual PREA report shall be made available to the public on the department's internet website.

#### AUDITOR CERTIFICATION

I certify that:

- ☒ The contents of this report are accurate to the best of my knowledge.
- ☒ No conflict of interest exists with respect to my ability to conduct an audit of the agency under review, and
- ☒ I have not included in the final report any personally identifiable information (PII) about any inmate or staff member, except where the names of administrative personnel are specifically requested in the report template.

Lynn S. Guyer

September 23, 2015

Auditor Signature

Date